Oral Hygiene

APRIL 1958

Delaware Park Lake, Buffalo. The 90th Annual Meeting of the Dental Society of the State of New York will be held in Buffalo, May 12-14.

In this issue:

ANOTHER LOOK AT HYPNOSIS

NOW—2-year results re-confirm effectiveness of CREST—the stannous fluoride dentifrice

HOW TO INCREASE HER BETWEEN-VISIT PROTECTION AGAINST DECAY

Today, when you instruct your patients in home tooth care routine, consider whether your recommendations take modern dental research into account.

Does the dentifrice you prescribe strengthen enamel against decay action? Is its effectiveness established by numerous studies reported in leading dental journals?

Study after study of Crest's effectiveness has been reported in leading dental journals. *All studies showed that Crest reduced dental caries in both children and adults, by an average of approximately 40 per cent.*

Now, still another report[1], published in the August 1957 *Journal of the American Dental Association*, again confirms the pronounced effectiveness of the Crest stannous fluoride formula.

Adults who used only Crest Toothpaste for 2 full years had 34 per cent fewer new carious lesions than adult users of a control dentifrice.

Make sure that your patients get the between-visit protection from dental caries so clearly shown by Crest's unparalleled clinical record.

Prescribe CREST—the only stannous fluoride toothpaste, and the only dentifrice that actually strengthens enamel against decay!

FLUORISTAN is Procter & Gamble's registered trademark for an exclusive combination of stannous fluoride and a fluoride-compatible polishing agent.

Crest TOOTH PASTE —fluoristan

PROCTER & GAMBLE
Office, Division of Dental Research
Cincinnati 1, Ohio

[1]Muhler, J. C. and Radike, A. W.: Effect of a dentifrice containing stannous fluoride on dental caries in adults. II. Results at the end of two years of unsupervised use. J.A.D.A. 55:196 August 1957.

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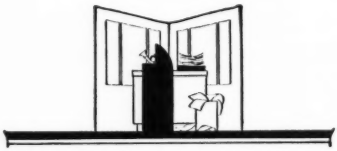
References: 1. Goodman, Louis S. and Gilman, Alfred: *The Pharmacological Basis of Therapeutics*, sec. ed. 1955. 2. Krantz and Carr: *Pharmacologic Principles of Medical Practice*, 1954. 3. Hammes, E. M., Jr.: *Pain-Relieving Drugs*, J. Lancet 79:67, Feb. 1952.

The Publisher's CORNER

By Mass



No. 441

All the little joes and jills

THOSE of us who live and work on the fringe of a great profession have an implied obligation to reflect credit upon our professional associates. Men engaged in the healing arts must look the part. And most of them do. Sharp-eyed, they keep tabs on the appearance of their personnel. But it isn't just a matter of haberdashery and millinery. The appearance of health is the first consideration. Personnel must, at least, look the part. It is, fortunately, possible to buy in a barbershop or a beauty salon the appearance of health, or at least a reasonable facsimile.

Some lucky souls have a built-in appearance of health. Thinking about that, ORAL HYGIENE thinks about its dear friend of many years, Ida Mae Stilley (now Mrs. Tom Maher). There's nothing artificial about Ida Mae's health. Ida Mae grows her own health and makes a beautiful job of it. Ah there, Ida Mae!

Diagnosing her case, this magazine is convinced that Ida Mae

(*Continued on page* 6)

April 1958. Monthly. Oral Hygiene, Inc., 1005 Liberty Ave., Pittsburgh, Pa. Subscription, $5.00 a year in U. S., Canada and Latin America; $5.75 elsewhere. Accepted as controlled circulation publication at Rutherford, New Jersey.

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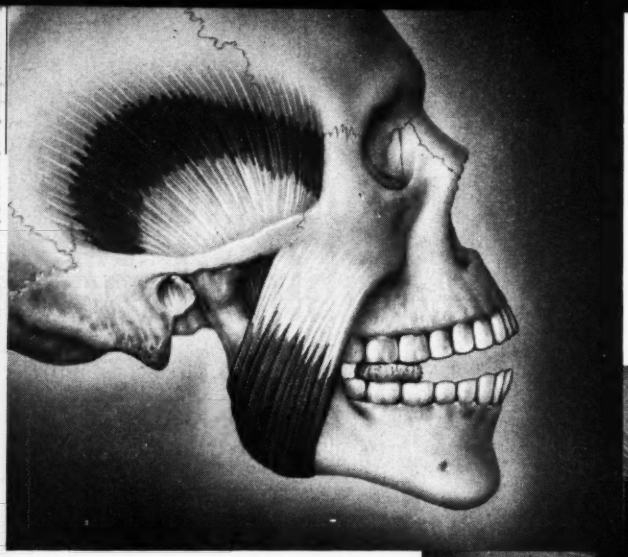

Chewing efficiency of natural teeth can be measured clinically in terms of the number of chews necessary to reduce food to a specific degree of fineness. The efficiency of dentures can be measured in the same manner.

2 **With normal efficiency** rated at par 100, the average efficiency among one hundred denture wearers dropped to 26. This loss was due partly to the discomfort and shock of chewing and partly *to denture instability.*

FASTEETH is the alkaline fixative powder that is made exclusively by Clark-Cleveland, Inc., Binghamton, N. Y.

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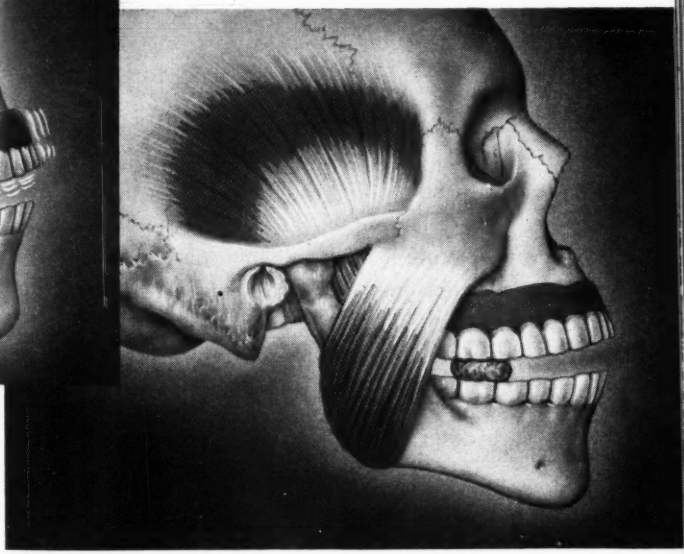
At least 74% of the normal chewing efficiency of natural teeth is lost in the average denture. Now, a special powder helps restore it.



3 **Average eating efficiency** rose sharply to 35 when FASTEETH fixative powder was sprinkled on dentures. FASTEETH forms a cushion between plates and sensitive gums relieving irritation and distributing shock. It also stabilizes dentures and makes it easier to eat the essential foods such as meats and fruits. It adds immeasurably to the attitude of the patient.

(*Continued from page 2*)

Ida Mae Stilley and "Happy," the whispering puppy

looks so grand, so downright all-fired healthy, not just because she gulps a vitamin pill now and then, but mainly because she is in love with her job. "And what job is that?" you demand to know.

Ida Mae just plain loves kids and they love her. Her love of kids sort of illuminates the scene when Ida Mae is around.

What's it all about? And what goes on and why? Well for the love of mike! We almost forgot Ida Mae's constant companion Happy—the lovable whispering puppy.

Happy is leading man in the show when "The Happy Story" is presented, and Ida Mae tells all the little joes and jills about dental health. And they love it. "The Happy Story" is now available in a 16mm sound film in full color, sponsored by the Auxiliary to the Pennsylvania State Dental Society, and introducing a new concept that not only teaches but inspires kids to practice good dental health habits.

Write to THE CORNER, care of Oral Hygiene, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania, for details.

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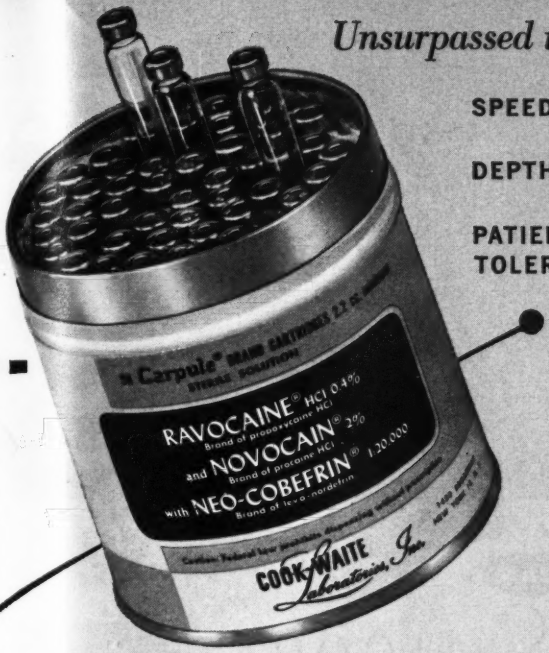

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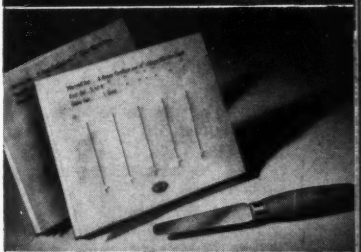

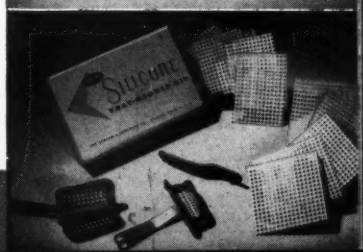

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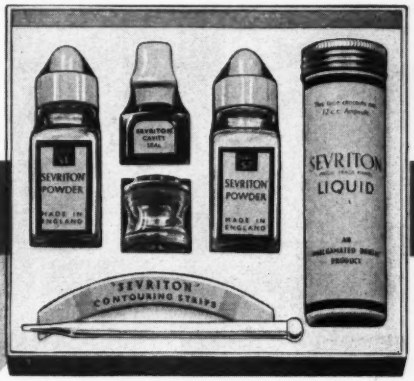

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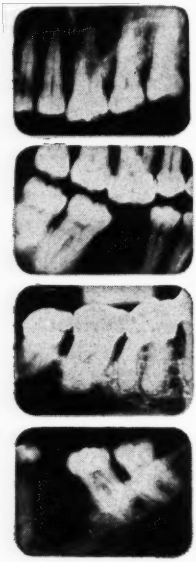
pain from hypersensitive dentine relieved in all of 92 patients[1]



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1. Fitzgerald, G.: Dental Digest, 62:494 (Nov.) 1956.

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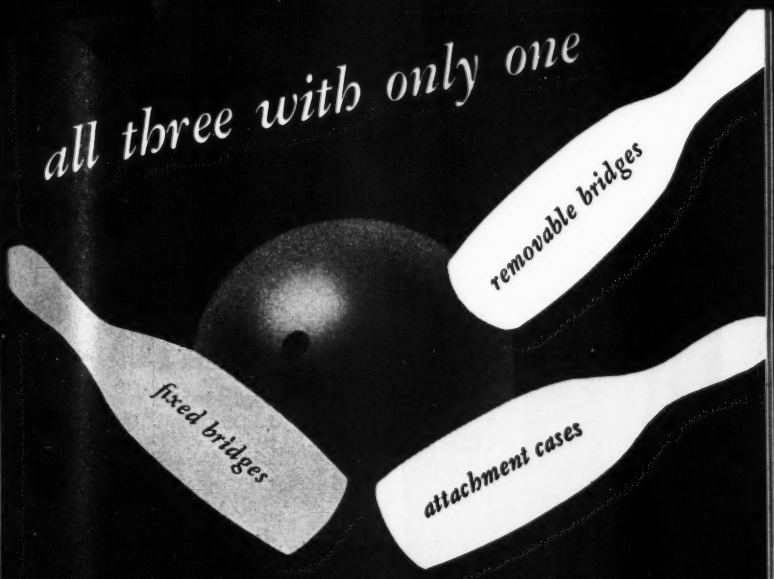

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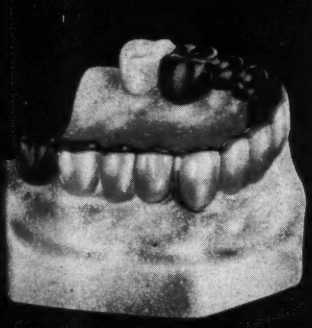

. . . Especially formulated to meet the rigid requirements for fixed bridges — it performs equally well for removable and attachment cases. Thus, Aderer No. 3 Bridge Gold provides the opportunity of accomplishing a complete mouth rehabilitation with one metal to minimize the possibility of galvanic shocks or discoloration from electrolytic actions when different metals are used. Aderer No. 3 Bridge Gold not only provides this outstanding advantage but also represents a slight economy over your favorite "all-purpose" gold which was formulated primarily as a partial denture gold and adapted to abutment, pontic and fixed work.

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Aderer Cast-Bridge Solder is an especially formulated alloy to help you complete a mouth rehabilitation case and is designed for use with Aderer No. 3 Bridge Gold to minimize the likelihood of galvanic action and discoloration. It blends in color with the No. 3 Bridge gold to give a "one piece cast appearance" to an assembled case.

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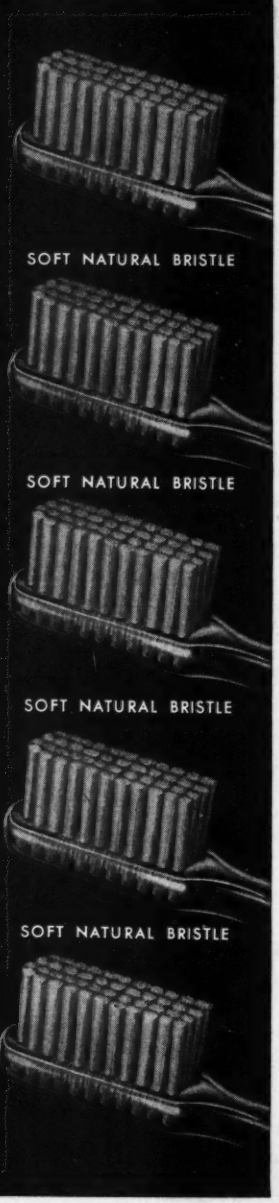

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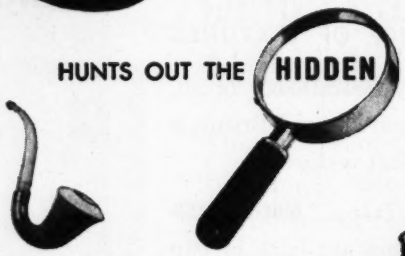

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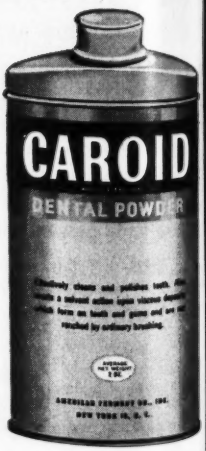

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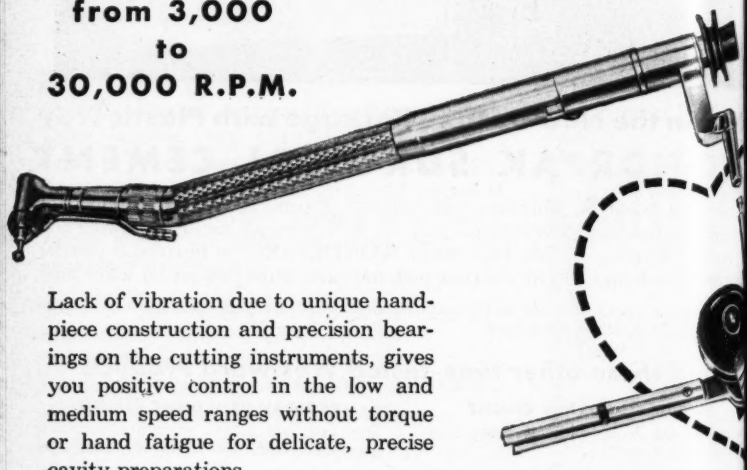

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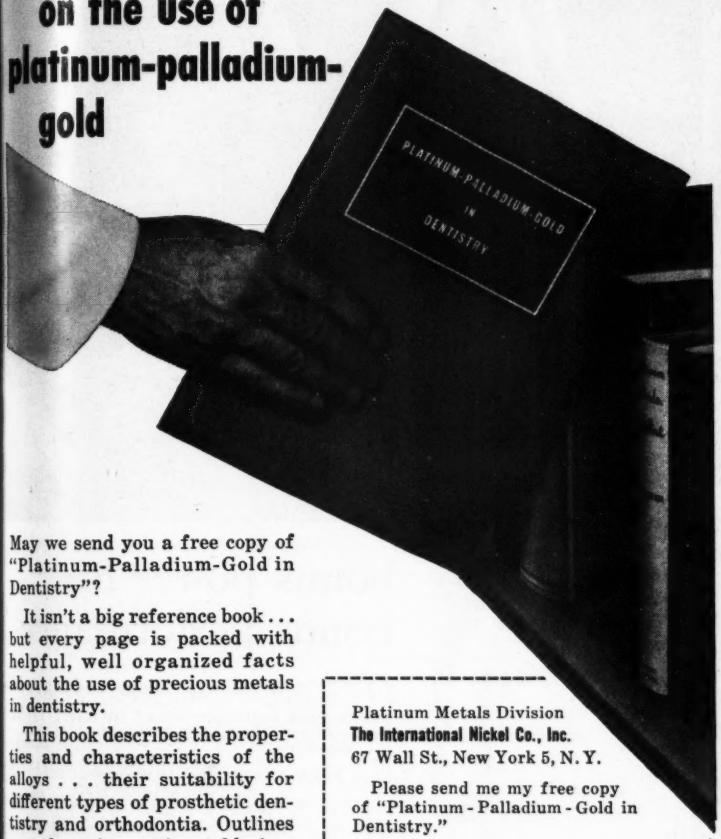

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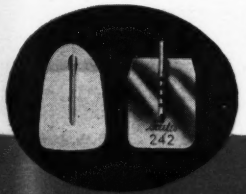

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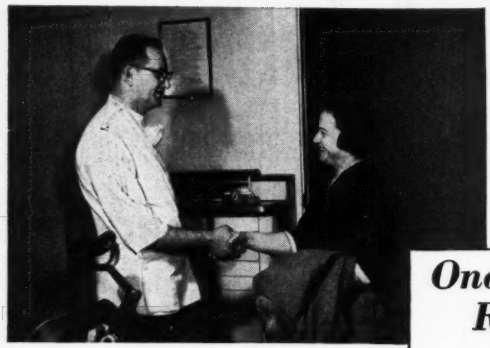

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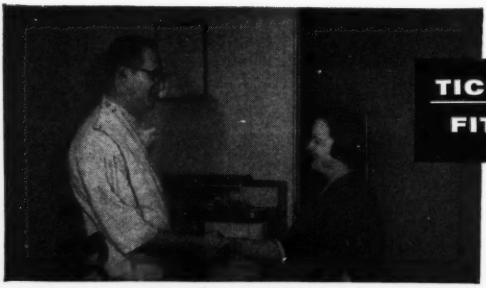

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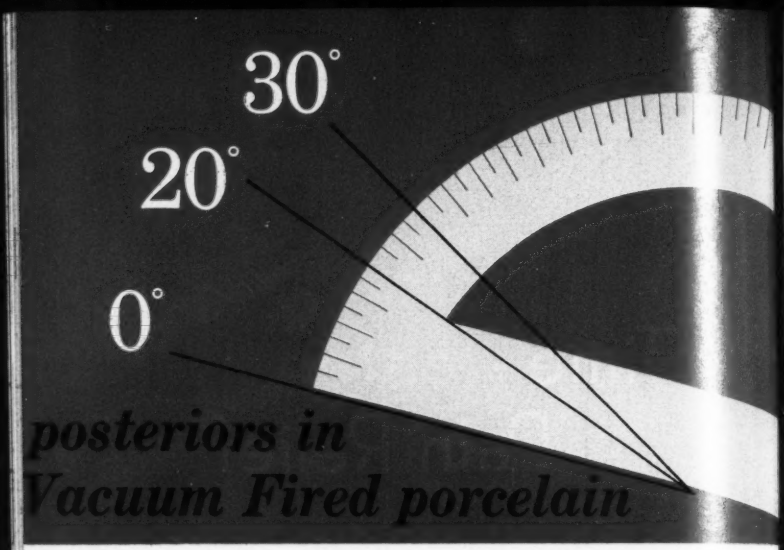

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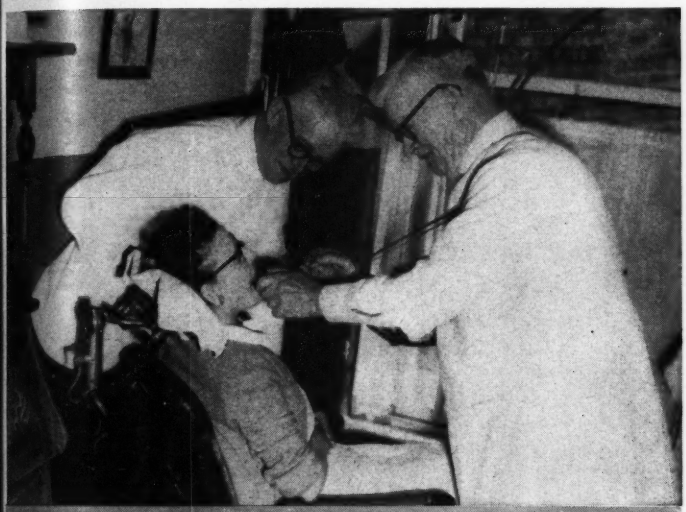
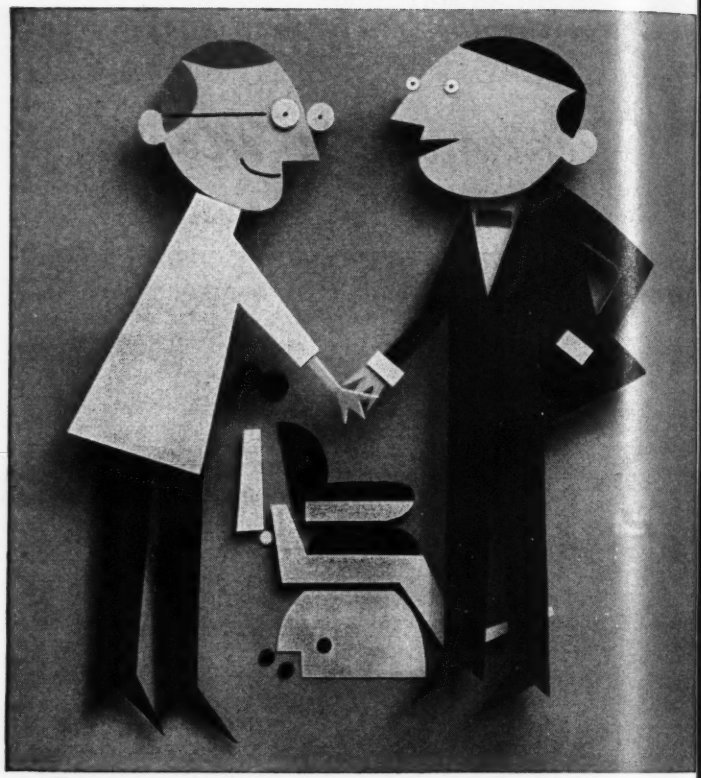
Picture of the Month



IDENTICAL dentists, Doctors Henry G. and Thomas D. Williams share the same office in Shelbyville, Kentucky. These vigorous 80-year-old brothers received twin loving cups in 1952 as the oldest twins at the International Twin Convention.

There is no confusion for the patients though, Doctor Henry specializes in restorations, and Doctor Tom handles the prosthetics and extractions.—*Wide World Photograph from Dixon (Illinois) Telegraph.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*



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Another Look at Hypnosis

BY J. S. GREENFIELD, DDS

BECAUSE of the two distinctly different points of view I have held regarding hypnosis in my more than a quarter of a century association with dentistry, I should like to discuss the effect our language habits have on our general attitudes and resulting behavior toward ideas.

The concepts on which I wish to elaborate in this article are directed specifically to the dentists, but are applicable in any situation in which responses to ideas and notions are involved, and in general in relation to our language use in human affairs.

While still a junior in dental school I made a study of hypnosis and practiced it within the limits set by the conditions, which a lack of interest plus many misconceptions on the part of the profession as well as the public imposed in 1930.

Are you keeping up to date? It may be well to pause and examine your attitude toward hypnosis.

The fact that I was self-taught also limited my knowledge of procedures and application to the dental patient. Not much had yet been done in this field, and pioneering invariably involved restrictions enforced by lack of knowledge. Two or three volumes on the subject were my only source of information.[1]

As a result of certain premises I held regarding the application of this age-old practice, which came from the few books available, I

[1]Bramwell, J. M.: Hypnotism: History, Practice and Theory, New York, Julian Press, 1956; Moll, Albert: Hypnotism, Chicago, Chas. Scribner's and Sons, 1890; Forel, A. H.: Hypnotism: Suggestion and Psychotherapy, New York, Allied Books Company, 1907.

soon gave up the idea of using hypnosis in the dental office, except in extremely rare cases. My convictions were so strong on this point that as recently as 1951 I wrote an article[2] in which I vigorously supported my position as to the impracticability of hypnosis as a tool in the hands of the dentist. This was based mainly on the fact that it was time consuming and could not replace or substitute for the exceptional chemical anesthetics we had at our command. I am happy to report that I have had an opportunity to express my present attitude to the readers of my first article.[3]

As a result of our conditioning, and primarily because of the lack of understanding the effect our language structure has on our behavior, we tend to hold onto and refuse to relinquish premises and assumptions which we once incorporate into our thinking. I have had the good fortune to discover a discipline,[4] which helped me to understand this kind of response to words and their meanings, and to this I give a great deal of the credit for my willingness to change long-held premises regarding hypnosis.

Discoveries are being made faster these days than thirty years ago, and I have seen more changes occur in my lifetime than could be witnessed by many generations a few hundred years ago. We have to be prepared to change our minds faster these days because of these rapid and sudden breakthroughs in the world of science. Korzybski has said, ". . . that human freedom is not absolute: that we are governed by logical fate. We are free to select our assumptions; if we select false assumptions disaster follows."[5]

About a year ago I was exposed to a group of dentists and physicians, who taught hypnosis[6] to the professions on an entirely different set of assumptions than I had previously encountered. Since then I have been able to drop my old notions, acquire new ones, and make good use of a procedure, which has been of inestimable value to me as an aid in general practice and in patient relationships.

To sum up the results of the foregoing I will list the attitudes which follow from the old premises as well as from the new.

Behavior Under Old Assumptions:

1. Each patient must be "thoroughly hypnotized"; if this does not occur you have failed.

2. Time consumed is long in some cases, therefore allow long periods of time. (This was a deterrent to its use.)

[2]Greenfield, J. S.: Hypnosis, Its Dangers in 1951, Cal **14**:4 (July) 1951.

[3]Greenfield, J. S.: Hypnosis—1957 Reevaluation. Cal. **20**:8 (November) 1957.

[4]Korzybski, Alfred: Science and Sanity: An Introduction to Non-Aristotelian Systems and General Semantics, Lancaster, Pennsylvania, Science Press Printing Company, 1933.

[5]Korzybski, Alfred: Fate and Freedom, "The Mathematics Teacher," **16**:274-290 (May) 1923.

[6]Seminars on Hypnosis, One North Crawford Avenue, Chicago 24, Illinois.

3. The hypnotist has "control" over patient. Failure or success, it then follows, depends solely on the operator.

4. Fear of failure dimmed enthusiasm for its use.

5. Hypnosis is a substitute for chemo-anesthesia. This is not always so, but can be true in some cases, and in others it is used in conjunction with other anesthetics to great advantage.

Behavior Under New Assumptions:

1. Anyone can be relaxed to some degree in a few minutes. This is often adequate for advantageous treatment.

2. Time consumed is little. If there is no success (relaxation) procedure can be halted in a few minutes.

3. No failures, since even 5 per cent relaxation eases tensions and adds greatly to the favorable dentist-patient relationship.

4. Hypnosis, a learning process, with continuous improvement on the part of the patient.

5. Patient has the control. This removes fear and puts the burden of success or failure on the subject, where according to present day knowledge it rightfully belongs.

6. It is not a substitute for chemo-anesthesia.

The principle of examining old assumptions, some silent and some we are not always aware of, can be applied widely in our relationship to people and situations we encounter in our daily living. Quite often checking our premises against the newer knowledge with a willingness to drop those which no longer correspond to the empirical facts of experience or science of this date (1958) will result in benefits and new behavior patterns far beyond anything we can ordinarily contemplate. We are slaves of our language habits.[7] We usually do not realize that our responses (semantic reactions—organism-as-a-whole responses to words or other stimuli in connection with their meaning), are greatly influenced by our awareness of the effect that words have on our nervous systems, and consequently on our day-to-day behavior. We tend to internalize our habitual responses to language structure, and then respond unconditionally to traditional views and assumptions without question.

Today there is a vast amount of literature[8] in addition to competent training in hypnosis available to the general practitioner, which can give him an instrument of great power he can employ almost daily to his patient's and his own advantage.

322 *North Main Street*
Bowling Green, Ohio

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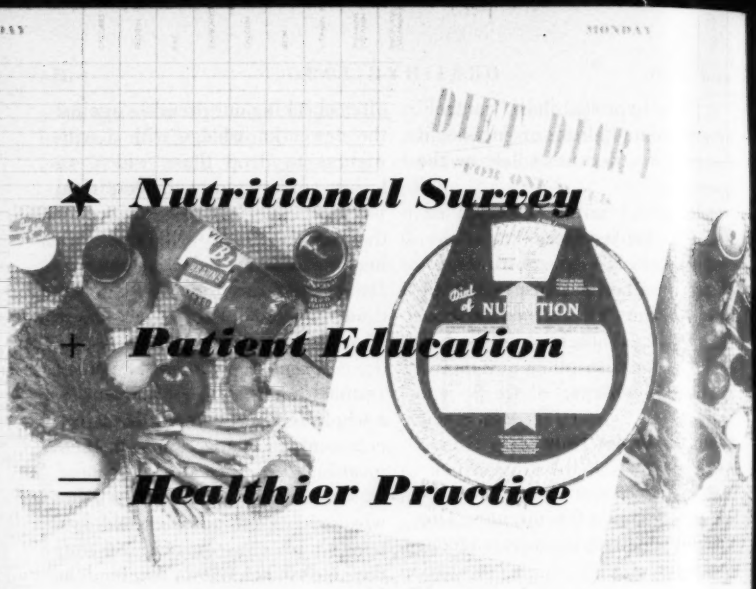
[7]Lee, I. J.: Language Habits in Human Affairs, New York, Harper and Brothers, 1941.

[8]Wolberg, L. R.: Medical Hypnosis, New York, Grune & Stratton, 1948; Weitzenhoffer, André: Hypnosis, New York, John Wiley, 1953; Moss, A. A.: Hypnodontics, Brooklyn, Dental Items of Interest Publishing Company, 1952; LeCron, L. M.: Experimental Hypnosis, New York, The Macmillian Company, 1952.



BY M. TRAVASCIO

BECAUSE the suburban area in which his office is located is heavily populated by young families, an eastern dentist is taking advantage of this made-to-order opportunity to conduct a special survey. The results, he hopes, will either confirm his present beliefs on the relation between eating habits and the dental health of teenagers or reveal new facts of value in a planned education program.

In his search for definite information on this vital subject he is currently limiting his investigation to boys and girls between the ages of 12 and 17 because he explains, "This is the age bracket in which a child becomes a person, starts to mature, and begins exercising individual preferences for food and beverages." Also, in an attempt to by-pass averages he is confining his survey to youngsters whose teeth look "as though moths had been at them" and those who require little or no dental corrections. As a start in his search for the information in which he is interested he has had multigraphed a quantity of 5 x 7″ cards on which the patients that fall into his study classification are asked to list the foods eaten the previous day and also a few other related questions.

Younger patients who might have some difficulty filling in the form are asked the questions verb-

Have your young patients fill out forms to aid you in a special survey to promote better nutrition.

ally by the dentist or his assistant, and the cards completed by the older boys and girls are reviewed hurriedly before the patients leave so any omissions may be corrected while the youngsters are still available.

In organizing his search for revealing facts on the link between nutrition and dental health, this practitioner is aware that his one-man campaign will be limited by the scope of his practice. "But," he argues, "the review will be benefited by my personal contact with each patient surveyed." Also, he has already taken steps to interest dentist friends and some of his association members in conducting similar studies in their own practices. "If I personally wind up with just sixty detailed reports," he points out, "that information will be of some value, but if ten other dentists gather similar facts and this multiplication continues in even a limited way the survey total will quickly climb into the thousands. And, a dentist entering such a project cannot help but improve his own professional practices and aid in the more general acceptance of dental services."

Like many others, this dentist has occasionally questioned patients about their eating habits, but since he previously did not chart the replies he had no conclusive nutritional facts to offer his young patients and their parents. "I would like to correct this condition and be in a position to advise authoritatively." In this objective he is joined by a host of dentists across the country who have been battling for more nutrition education while patients are being given dental care. One Florida practitioner has insisted that this should include not only guidance on food selection but on storage, preparation, and quantity and frequency of consumption. This, it is claimed, will tend to nullify the evils brought about by commercial catch phrases and claims made as the result of impersonal controlled investigations.

During the early stage of his information gathering the inquiring suburban dentist has found that cooperation of youngsters is gained more readily through emphasizing the possible lessening of future dental discomfort, while parents listen more attentively to nutrition advice when it is tied in with the health of the whole child and its contribution to the reduction of costly dental corrections. This latter fact was brought out in the case of several parents who telephoned the dentist when their youngsters reported that they had been asked to fill in the food and beverage questionnaire. Each mother or father who called indicated enthusiasm when the pur-

pose of the project was explained, and asked that they be given more details when the study reached proportions that would permit factual conclusions.

Children More Truthful

When the special project was first considered the question as to whether the parent or the child was the more reliable source of information was weighed carefully. The latter was decided on because of the tendency of most mothers and fathers to insist that, "William eats his spinach and drinks his milk regularly," because that sounds like the proper answer. Also, parents are inclined to simply by-pass any reference to the soft drinks, candy bars, and rich cookies included in their youngsters' snack and mealtime menus. In contrast, "Most youngsters," the dentist has found, "have surprisingly accurate memories when it comes to recalling what they had to eat yesterday and give a truthful report."

In limiting his questions to the food and beverages consumed during a single day, the dentist is purposely trying to avoid becoming too involved. He has found that this gives him accurate information since a family served potatoes, corn, lima beans, bread, and a pastry dessert one day is likely to be offered a comparable fare frequently. The home in which green vegetables, salads, and fruit desserts are provided one day will receive the same or similar menu at regular intervals.

As indicated earlier, the above average number of youngsters in the area served by this dentist has provided him his opportunity to search for some revealing facts. But he was also provoked into the interesting project through a realization that his patients were depending on nonprofessional sources for information that should originate in dental offices. "Being oral health authorities and dental specialists," he insists, "means that I and the members of this profession have the responsibility of doing a complete job. This calls for correcting dental faults, of course, but it also requires that every effort be made to provide preventive information through regular and repeated patient education. If," he continued, "certain foods and beverages are found to be prime dental offenders they should be named, patients advised and the information passed along to all dentists, medical practitioners and public health authorities."

While the nutrition-minded dentist did not mention it, commercial organizations would also be interested because it would equip them to make product changes or adjustments that would eliminate the evils. Thus all concerned would benefit.

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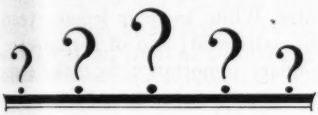
So You Know Something About DENTISTRY!



BY ROLLAND C. BILLETER, DDS

CLXIII

1. Why must extreme caution be exercised when removing the torus palatinus? .....

2. True or false? Black or badly discolored castings that do not clean up readily when pickled may be the result of incorrect burnout technique. .....

3. Self-cured resins normally contain a somewhat (a) higher, (b) lower, residual monomer content than the heat-cured resins .....

4. Is an open mouth indicative of mouth breathing? .....

5. With the barbiturates, the alteration of pain perception that leads to the analgesic state (a) is, (b) is not, produced. .....

6. After the first permanent molars, which of the teeth are most likely to be lost? .....

7. In older people the oral mucosa becomes (a) thicker, (b) thinner. .....

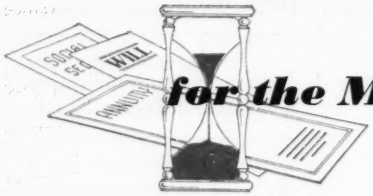
8. True or false? One attack of generalized herpetic stomatitis seems to confer immunity to further episodes. .....

9. Is syncope dangerous in the normal patient? .....

10. About (a) 25, (b) 40, (c) 55, per cent of amalgam restoration failures are due to faulty cavity preparation. .....

FOR CORRECT ANSWERS SEE PAGES 78 and 80

An Estate Plan for the Mature Dentist



PART II

BY ALLAN J. PARKER, LLB, LLM*

IN THE last issue of ORAL HYGIENE a discussion was undertaken of an estate plan for the younger dentist, broadly defining estate planning as the new and developing field of financial protection for a person's family and for himself in his old age. This article will attempt to discuss the problems of the mature dentist.

To illustrate the flexibility and importance of estate planning for the dentist, let us take the hypothetical case of Doctor John White. We assume the following facts: a wife and children; a moderately prosperous practice; maximum Social Security coverage for retirement ($162.80 per month for husband and wife); about $50,000 in ordinary life insurance, and about $50,000 in all other assets, including his home.

Doctor White's major objective in his estate plan are, first, to provide reasonable security and some degree of comfort for himself and Mrs. White in their leisure years of retirement; and of perhaps secondary importance, to make some provision for his children or grandchildren.

Doctor White recognizes that one of the significant attractions of his self-employed professional status is that at the age of 65 he is not given a gold wrist watch, a handshake, and then turned out to pasture on perhaps an inadequate pension and cut off from the professional responsibilities that have become so important a part of his life. It is possible for a professional man of his status to enter into a state of semi-retirement by gradually and voluntarily reducing the scope of his practice. For example, it might be possible for him to bring in a younger dentist to share his office on some basis as a profit-sharing arrangement, perhaps eventually leading to a purchase of the practice by the younger man. Of course, there are limita-

*Mr. Parker is a member of the New York Bar.

You can provide security for your family, and a retirement fund by following the author's suggestions.

tions imposed on how much Doctor White may earn without losing Social Security retirement benefits.

The eventual sale of his practice might be made on a percentage of income basis, which would assure Doctor White of a retirement income for a few years at least. And since income *after* taxes is what we all live on, from an income tax point of view, the proceeds of the sale would be largely tax-favored capital gain, only half of which is taxable at all, and which is never subject to a rate greater than 25 per cent.

Insurance

A second important phase of Doctor White's estate plan is the disposition of his insurance. With his family now grown and the period of greatest need for protection for a young family at an end, Doctor White may now consider applying all or a part of his life insurance to his own retirement needs.

One minimum possibility would be to relieve himself of the burden of paying annual premiums of $800 per year. He need only surrender his policies for paid-up insurance in a slightly reduced amount, say, about $30,000.

A still further possibility would be to turn the cash values of his insurance into monthly income payments for himself and Mrs. White for the balance of their lives. This can be accomplished by turning his life insurance into an annuity—an alternative that is provided for by many ordinary life policies, particularly those of more recent issue.

An annuity is in some respects the converse of a life insurance policy. Whereas a life insurance policy protects the insured's family against his failing to live his life expectancy, an annuity protects the insured against living so long beyond his life expectancy that his assets, principal and income, would be exhausted, and he would have no money on which to live in his old age.

Varying insurance policies pay different amounts as annuity payments, depending, of course, not only on the amount of cash reserve in the policy, but also upon the age of the insured and the individual insurance company's contract.

There are many possible variations on the annuity pay-out provisions. The first of these is the so-called straight-life annuity. Here the insurance company agrees to pay to the annuitant beginning, say, at age 65 the stipulated amount of money each month, all payments to terminate at his death.

Most annuitants, however, dislike the gamble that they may receive only one pension payment

and then die. This does not mean, of course, that the balance of the fund is clear profit to the insurance company; the money, according to the risk-sharing principle, is paid to other annuity holders who live for a long time and receive much more than the cost of their annuities.

To soften the harshness of this possibility, many insurance companies recommend an annuity with installments certain; that is, no matter when the retired dentist dies, his beneficiary or his estate will continue to receive monthly payments until 120 payments in all are recovered.

Another alternative includes the so-called refund annuity which guarantees, in the case of early death of the annuitant, to pay to his designated beneficiary or his estate an amount equal to the money which he paid for the annuity over the course of his life. Still another method of distributing the benefits under Doctor White's policy might be to take the proceeds as a joint and survivorship annuity payable over two lives, with payment terminating only on the death of both Doctor White and Mrs. White.

Needless to say, where the insurance company is required to make payment for at least ten years, to refund the annuitant's unrecovered cost of the annuity, or to spread payments over two lives, the amounts payable each month under the annuities are smaller than they would be if they were paid out as a straight-life annuity. The whole question of payout should be considered by the retiring Doctor White with his insurance advisor. Usually it is possible to change the method of payout in accordance with changing family or financial circumstances.

While the annuity received may not be too large in itself, it should be borne in mind that Doctor White's social security benefits are income-tax free, and the insurance annuities are taxed in a special way, resulting in a reduced tax.

The tax treatment of the annuity is favorable, because essentially, the tax law recognizes that a substantial portion of the amounts which Doctor White receives from his annuity each month represents a return of his lifetime investment, or savings, not taxable income at all. Since Doctor White received no tax deduction when he put the savings into the policy, he should not have to pay taxes when he takes them out. The law computes the amount which should be excluded each year (or exclusion ratio) from the taxable portion of the annuity, if Doctor White is to recover his investment over the period of his life expectancy. Only the relatively small balance is taxable income. However, if Doctor White lives beyond his life expectancy, and has by then recovered all of his investment in

the annuity, the tax laws give him a bonus—he nevertheless may continue to exclude the same portion of each monthly payment without change. Thus, from a tax point of view, too, it is much to his advantage to outlive his expectancy.

The variations on the straight-life annuity pay-out of an insurance policy reserve, require the tax-excludible portion of the payments to be adjusted downward in recognition of the additional features provided.

The third aspect of Doctor White's estate plan is to review his last will and testament. A will, of course, cannot create additional values for Mrs. White's protection after his death. However, it can greatly simplify the handling and administration of his estate, and can save a substantial amount of trouble and money for the widow or other surviving heirs.

120 *Broadway*
New York 5, *New York*

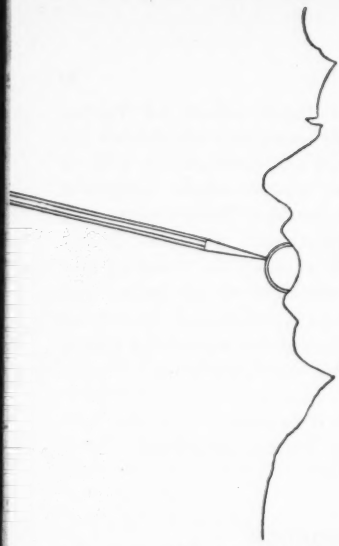
WHO APPROVES FLUORIDATION

THE World Health Organization has reported that the use of fluoridated drinking water to prevent tooth decay is safe, effective, and practical. After having studied hundreds of fluoridation programs in 17 countries, a WHO committee has announced that the use of fluorine in drinking water supplies is approved by responsible public-health officials throughout the world.

In the United States 32 million people in more than 1500 communities are drinking fluoridated water. Sixteen other countries have begun similar programs.

The WHO committee report emphasized that results in all nations using fluoridated drinking water show remarkable uniformity. Dental caries in the permanent teeth of children decreased by about 60 per cent, while in children's primary teeth the reductions ranged from 50 to 60 per cent.

No other public-health procedure has had, during the initial stages of its application, such a background of study in terms of both time and expense, the report said. Without qualification or caution, WHO recommends the use of fluoridated drinking water wherever and whenever possible. It was suggested that treated water contain 1 part of fluorine for every 1 million parts of water. NEWS OF SCIENCE, *Science* Magazine September 20, 1957.



April Is Cancer Control Month

BY ARTHUR ELFENBAUM, BA, DDS*

IT IS possible that the day may come when the public will be educated to refer anything and everything involving mouth pathology or discomfort to the dentist, and when all dentists will have enough experience to diagnose or, at least, give some consideration to such conditions. Who does the treatment is not so important, but the battle is half won if the dentist realizes that an abnormal or pathologic condition exists and that it needs or does not need attention. While it is true that about one-third of all patients with cancer of the mouth have been seen in a dental office, we do not know whether these patients consulted the dentist of their own volition or if the practitioner discovered the oral lesion without the patient being aware of it. Furthermore, we should be concerned about the other two-thirds whose oral malignancies were seen by someone else.

Actually, the detection of cancer of the mouth does not require any specialized training, knowledge, technique, or instrumentation. If it exists, its discovery should be part of the routine survey given to every mouth irrespective of the patient's reason for the consultation. All dentists are capable of investigating the teeth and the occlusion, but more emphasis must be placed on the examination of the oral soft tissues. The lips, oropharynx, and neck are also now considered to be within the domain of dentistry so far as a mouth examination is concerned. When the

*Doctor Elfenbaum is Professor Emeritus of the University of Illinois and Northwestern University; and Consultant in Diagnosis at the Dental Training Center of the West Side Veterans Administration Hospital and the Dental Department of Michael Reese Hospital, Chicago.

If you have never detected a case of cancer of the mouth, perhaps it is because you are not giving a complete oral examination.

roentgenograms show a radiolucent area, it should not always be taken for granted that it represents an abscess, cyst, or granuloma, especially if the patient has a history of cancer of the thyroid, lung, kidney, prostate, ovary, or rectum. Occasionally the mandible is the site of a secondary involvement from a distant malignant lesion.

An 11-year-old boy was referred to us by a dentist who was requested to extract a loose primary molar, but the odor from the child's mouth was so unusually fetid, that the dentist decided to remove some of the abnormal looking gingival tissue around the tooth and have it biopsied. It proved to be a carcinoma, and the patient was sent to us for further investigation. Biopsies were made from the palpable cervical and inguinal lymph nodes. Squamous cell carcinoma was widespread, and despite x-ray therapy and surgery, the boy died. Luckily for the dentist, he did not remove the loose tooth and dismiss the case. Had he done so, he would no doubt have been blamed for the malignancy, which would have been uncovered later when the child became extremely ill and hospitalized under a physician's care.

It is indeed remarkable how often a squamous cell carcinoma of the gingivae is assumed to be an abscess and the involved teeth extracted. The surgery only aggravates the situation. Cancer cells can multiply rapidly even in an immature stage. Their wild growth is matched only by their rampant invasion of tissue into which they extend their tentacles like a mad crab ("cancer" is a Latin word for crab). If the tentacles attach themselves to a muscle, the consequent immobility of the tumor substantiates the diagnosis of malignancy. A benign cyst is more freely movable. Cancer cells also float themselves into the blood stream and lymph vessels, and eat into another area at a distance from the original site. Metastasis *from* a malignant oral lesion usually settles somewhere above the clavicles, and metastasis *to* the oral cavity may come from quite a distant region.

We had a patient with a rapidly growing ulcer on the lower lip, but, since he told us of pain in swallowing, even water, we ordered an x-ray of the tract down to the stomach and found a carcinoma of the esophagus. Surgery to remove the lip lesion with cosmetic results in view would have been foolhardy if the esophageal pathology had been overlooked.

No Pain Warning

Pain from an oral malignancy is not a good guide. Cancer is usually not painful in its early stage, al-

though a beginning sarcoma of the jawbone is extremely distressing. However, early malignant neoplasms of the oral soft tissues may be affected by injuries, chemicals, bacteria, and temperature changes, and become secondarily infected. The infection, rather than the original lesion, then develops into a source of pain. If the infection can be cleared up, the pain may be alleviated. Only in the advanced stage, when the tumor exerts pressure on nerve fibers, the patient suffers pain. The symptom may also be referred to other parts of the mouth, jaws, or face.

In a routine examination of the mouth the tongue is often neglected. If lesions are present on the dorsum of the tongue or borders, they may be seen readily. The ventral surface comes into plain view when the tip is placed against the palate just posterior to the upper anterior teeth and the mouth is opened wide, but the base of the tongue is not easily examined unless the tip is held firmly with gauze and pulled forward. At the same time the anterior pillars of the tonsils should be surveyed. About one-quarter of all oral cancers occur in the tongue.

Cancer in the floor of the mouth is not too common, but when it does occur, the prognosis is extremely unfavorable. It usually begins alongside the lingual frenum and spreads rapidly to the other side and deep into the tissues, even into the jawbone. If the lesion is palpated with one finger, the soft tissues below it are depressed, making it difficult to evaluate the induration of the tumor. The mylohyoid muscle must first be immobilized by pressing the fingers of one hand against it on the submental surface; then the palpating finger inside the mouth can determine the location and hardness of the neoplasm. Whenever a malignancy is suspected in the mouth and palpation is deemed necessary, the finger should be gloved for protection against possible secondary infection, not against the cancer itself. Too much manipulation must be avoided; excessive pressure and pinching may force cancer cells into the blood or lymph channels and set up a metastatic process.

Leukoplakia

Whitish oral lesions frequently bring thoughts of cancer to the mind of the observer, whether the patient or dentist looks at them. Some of them, like moniliasis, lichen planus, and drug burns, are benign; but suspicion is justified when the tissues are hyperkeratotic. The epithelium is piled up and feels granular. It has been called leukoplakia, but the term is inadequate, because it merely means "white patch" and tells us nothing about the degenerative process or the etiology. The cause may vary from a local injury, irritation by spicy foods, or tobacco, or the constant use of drugs, to a vitamin A

PREMONITORY SIGNS OF ORAL CANCER

At the Annual Scientific Session of the American Cancer Society, Doctor George S. Sharp, Pasadena, California, reported his study of 100 patients with oral carcinoma. Complaints referable to the mucous membranes were listed by 81. These complaints included, in order of frequency: soreness, dryness, burning, denture irritation, and recurrent herpes. These conditions were thought to have been present *prior* to the cancer. In 87, signs of abnormalities of the mucosa were seen in association with the cancer: they, too, were assumed to have been present prior to the onset of the carcinoma. The most common abnormalities were atrophy (in 74) and leukoplakia (in 58); 46 patients showed both conditions. Doctor Sharp stated that when the signs of both of these conditions were found simultaneously, the precancerous significance of them should be recognized.—*Medical Science, Philadelphia, J. B. Lippincott Company.*

deficiency, syphilis, or an endocrine disturbance. Discontinuance of the causative factor or treatment of it may be therapeutic, but it is the duty of both dentist and patient to observe the tissues regularly to evaluate any changes. Hence, it has been said that leukoplakia can sometimes be treated with "studied neglect," implying that the condition may be reversible. However, if the lesion develops a tannish color and cracks form in its surface, the probability is that there is invasion into the deeper tissues and a biopsy is necessary for diagnosis. The histopathologic examination may well prove the lesion to be a squamous cell carcinoma.

A conscientious dentist can hardly afford to neglect reading the available literature on oral cancer, but one must admit that many of the accompanying illustrations are horrifying. Pictures of eroded lips and faces that are eaten away help to exaggerate the admitted treachery of cancer, and the practitioner may become cancer-prone, wanting to check up on every oral tumor, ulcer, or other lesion. Cancerphobia in a dentist is worse than in a patient. The fear of being blamed for neglecting or overlooking a malignancy can really make one neurotic. However, many of the horror pictures in textbooks and articles are of neglected cases that are generally presented in hospital clinics. In most dental offices the main concern is with the early lesion. The dentist can approach

it with thought and understanding, and he can seek help if he feels he needs it. He must never "unload" a patient onto a specialist, dental or medical, and thank his lucky star that he got rid of the case. The patient consulted *him* in the first place, or he was the one who suspected or discovered the malignancy, and it is his duty to follow through. He should request a report from the specialist and ask the patient to return occasionally so he can see what happened. His future service may be needed for oral rehabilitation.

April has been designated by the Congress as cancer control month. Let us take a little more advantage of the opportunity we have and help eradicate oral malignancy in every way possible!

431 *Oakdale Avenue*
Chicago 14, *Illinois*

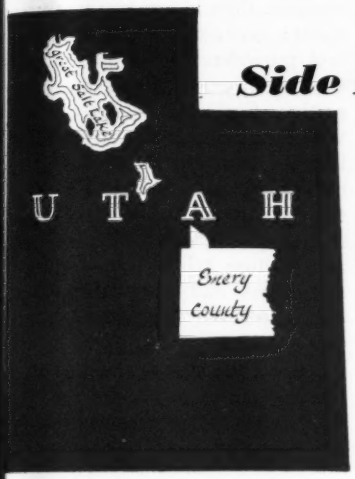
THE COVER

THIS MONTH'S cover photograph of Delaware Park Lake in Buffalo, represents an invitation to the 90th Annual Meeting of the Dental Society of the State of New York, which will be held at the Hotel Statler, Buffalo, from May 12 to May 14. For reservations and information about the meeting please write to Doctor C. A. Wilkie, 1 Hanson Place, Brooklyn 17, New York.

THE SIGNS OF GOOD NUTRITION

WELL developed body.
Proper weight-height proportion.
Firm, well-developed musculature.
Turgor and color of characteristically healthy skin.
Adequate fat pads beneath the skin.
Bright pink mucous membranes, free from lesions.
Smooth, glossy hair.
Clear eyes, free from dark skin shadows.
Alert facial expression, free from strain.
Normal posture, erect head, flat shoulders and abdomen.
Optimistic, enthusiastic attitude.
Feeling of well-being and buoyancy.
Sound, refreshing sleep.
Regular, adequate processes of digestion, assimilation, and elimination.
Eager, hearty appetite.
Appearance reflecting general well-being.

WAYNE MCFARLAND, MD. *Modern Nutrition, Los Angeles California.*



Side Lights of Uranium Prospecting

PART I

California dentist tells of his experiences traveling through the Utah deserts in search of uranium.

BY BERNARD F. EDERER, DDS

THE NIGHT wind blew across the Colorado Plateau hurling small stones and sand against our tent. The sound of the storm awakened me. I could smell dust, and even taste it. I found my flashlight in a small pile of sand, and pressed the button. Through the dust-laden air the beam of light picked up my wife's sleeping bag, which I saw was half covered with sand. She removed the bandana handkerchief that was protecting her face long enough to exclaim, with a slight note of disgust, "I certainly didn't expect anything like a black blizzard on *this* vacation!"

"Just another side light of prospecting," I called back with a grin. And so it was on each vacation trip to the Colorado Plateau; we experienced unexpected incidents that added more interest to the life of being uranium prospectors.

Strangely, I had never in the years gone by, even dreamed of being a prospector. My hobbies were slanted more toward hunting and photography. Thus it was that I found Utah such an ideal place for both avocations. Each year we would make our annual trip to the Mormon state. Each year we would hear more and more talk about uranium. Everyone was looking for the new atomic ore, or was planning to make a strike.

Our rancher friend, Delon Olsen, encouraged us to learn something about the science of pros-

pecting, and he in turn would guide us and help with the saddle horses, because much of the area was difficult if not impossible to traverse with motor vehicles.

We bought books on geology and minerals, and soon discovered we were using strange terms such as Cretaceous, Jurassic, Triassic, and Pennsylvanian, to describe the earth's systems. More frequently the formations in these systems came into our conversation. Most common were the Morrison, the Shinarump, the Moenkopi, the Chinle, interspersed with the names, Wingate, Green River, Dakota, and Wasatch formations. The names of uranium found in these formations were the easiest to remember. First in our area was carnotite; then, autunite, uraninite, and pitchblende with all the associated ores, including the rare earths. Curiously, these earths were used first during the last century for the manufacture of incandescent gas mantles. Today, their use extends to the making of motion picture projectors, television picture tubes, lighter flints, sun glasses, and many other modern inventions. It all was highly interesting; but so confusing when we found out that the rare earths were not earth at all, but metals. This familiarity with the impressive sounding names did not seem

Doctor Ederer searching for uranium in the rocky cliffs of the Colorado Plateau.

to endow us with any practical knowledge of how to find uranium. It was like trying to memorize Gray's Anatomy in one reading. "Why not forget it all and follow the amateur's theory that uranium is where you find it, instead of the geologist's theory that uranium is where it is supposed to be," our congenial rancher friend suggested.

The Search Is On!

This is what we did. Armed with a geiger counter, scintillator, cold light (ultra violet lamp), maps, jeep, and all the essential accessories, we left California and drove to the Colorado Plateau to meet our friend, Delon Olsen.

We undertook our first prospecting trip on a balmy March day, when an early thaw had removed all the snow from the scenic desert region in Emery County, Utah.

The dust storm area I mentioned was a rough introduction to the sport of prospecting. My wife found dust in her hair and in her pack sack, and sand in her face cream. We all experienced the crunch of sand in the food we ate. Water was scarce. We had to water the horses each day at midafternoon, when the muddy water from the melting snow from higher altitudes came tumbling down the otherwise dry creek bed.

After a few days of combating the dust and sand of Last Chance Wash, our guide decided to saddle up and pack our camp to higher ground among the cedar trees. Here, sheltered from the weather, with our meat and supplies refrigerated in a hole in the ground, we felt secure. But, not for long! The wind, which had been blowing from the east, suddenly turned to the northwest. Snow began to come down at nightfall. By midnight a blizzard was roaring across the mountain-side. Morning found us snug in our down sleeping bags with the intent to stay there all day. However, a yell from our rancher companion caused me to dress in a hurry and investigate the reason for his outcry.

"Look, Doc, my durned teeth are frozen solid," cried Delon, holding a tomato can toward me.

Sure enough, there in the tomato can were his dentures, wedged solidly in what had been water the night before.

With a fire of piñon knots we soon thawed the ice and restored the teeth to my friend's mouth.

Snow and prospecting do not go well together, because the instruments do not record well with the ground insulated by a blanket of snow. By necessity, we again moved down to the desert just in time to face another severe dust storm as we entered the Willow Creek area.

An Unusual Storm Shelter

"Can't put up a tent in this wind," yelled Olsen from behind the bandana he had tied over his face. I'll lead you to a line cabin

a few miles from here where we can find good shelter."

The line cabin, a two-room structure, was a winter home for three ranchers who had cattle on winter range in the desert. We were welcomed inside, and there we stayed for three days while the wind roared and shook the small building, nearly lifting it from the foundations.

My wife, Olsen, and I, slept in the room with the stove and the table, while the three ranchers slept in the adjoining room. Strangely, the oldest of the cowboys got up each morning before daybreak, lighted the kerosene lamp, and proceeded to make sour dough biscuits. On account of occupying his kitchen, we were forced to arise, too.

My wife's dressing room was a dusty corner of the bleak cabin room, the walls of which were adorned only by a few old calendars dedicated to pin-up girls. I held a blanket while she dressed, and then we all sat down to a hearty ranch breakfast of sour dough biscuits and jam, bacon, eggs, and steaming black coffee. We sat all day listening to range talk. It was like being isolated in another world. Though, somehow, we did not find it boring. The relaxation and rest that came with a complete change of thought and ideas were refreshing.

The routine of discussing caries, gingivitis, and malocclusion, was supplanted with talk of cattle, mining, and even archeology, especially related to primitive Indians who inhabited this area hundreds of years ago. My only scientific observation during these stormy days was to ponder the possibility of the ill effects upon the teeth and stomach of frontier people who consumed such large amounts of soda in their sour dough cooking.

When the weather cleared, the fleecy white clouds that usually float over the Utah skies, appeared above us to promise fair and warmer weather.

Our rancher friend thought it urgent for him to return to his home. Before leaving, he directed us toward Sinbad desert. In our Willys jeep, we bounced over a rough dirt road, through Buckhorn, Wash, out onto a most interesting desert, part of which has still been unexplored by the government surveyors.

We came upon several unique and interesting ancient Indian writings on the canyon walls, some mutilated by white travelers who had passed along the trail. Nearby, on the banks of the San Rafael River we saw a name etched in the rock wall that was synonymous with the old West. It read, "Jim Bridger, 1846."

Our stay here was brief, despite the fact that our instruments registered everywhere we went. Our excitement was cut short upon meeting a grizzly, old, bearded prospector who informed us that it was the fall out from an atomic

explosion in Nevada that made all the radiation count on our instruments.

"Why you know, a fella can get a real good count on the streets of Salt Lake," he mumbled with a wry grin, as he rode away on his mule.

With this startling information we returned to our home in California and the practice of dentistry, where I was more accustomed to dealing with the x-rays than the gamma and beta rays of rock.

We Have Not Given Up!

Many weeks later we were again in the Utah desert regions searching for uranium.

Our first camp was in a deep, sheltered basin. The morning sun had just begun to warm my sleeping bag when I felt something bite my hand. Thinking first of snakes, I sat up with a start. Huge ants were running over and into our sleeping bags, because, almost between us, was an ant hill. When I had made our beds in the dark of the preceding evening, I was so tired that I had unwittingly placed the head of my sleeping bag on the mound in order to improvise a pillow.

We traveled further on that day, with evidence everywhere of the dangers of the desert. There were bloated carcasses of cattle that had died of drinking poison water. We came upon the skeletons of burros and horses that were bleached white by the desert sun. Naturally, we stopped each time so I could observe the teeth. While I was seeking a reading on my geiger counter in the shade of a rocky ledge, my wife gave a startled call. Just below us was a huge rattler with his whirring tail warning us of his deadly presence. We were stunned, because someone had informed us that there were no rattlesnakes in Utah. This was our first rattler, but not our last. Later on in another area one evening, we came upon an interesting specie, the sidewinder, which humps across the sand in a willowy side motion. History has recorded areas in the early West where these snakes were so dangerous along the night trail that no one dared travel after dark.

By this time, we had adopted as our theme song, "The Shifting, Whispering Sands." My wife hummed or sang parts of the melody as we struggled about the desert. Seeing her so cheerful trudging through the sand, I came to full realization that here was the greatest side light of our prospecting tour.

She proved to me that a woman accustomed to all the conveniences of modern living could face the frontier privations and dangers with the same fortitude as the pioneer women. Watching her plod along in her heavy engineer's boots, I remembered her preference for delicate, flimsy, high-heeled pumps, but she adjusted

(*Continued on page* 59)

Your home camera may be used to advantage. Interior views will remind you of the many small items so often overlooked.

Why You Need an Inventory of Your Possessions

BY AL DRAYTON*

*Member, National Board of Fire Underwriters, 85 John Street, New York 38, New York.

YOU NEED an inventory of your office and household furnishings and personal property because it will provide you with:

1. A visual record of all your personal belongings.
2. Information upon which to base your present insurance so that all property will be covered.
3. Evidence for use in the event of loss, helpful in the preparation of your claim.
4. The basis for review of coverages.

Fire is always a possibility. Are you prepared to give an accurate estimate of your valuables?

If you have fine arts, jewelry, furs, or valuable books or curio collections you may wish to have them appraised to determine their present-day value.

How To Make An Inventory. Take each room separately—go into that room and list everything in it. Do not trust your memory.

It is easy to estimate the present-day value of your possessions as a basis for insuring them. If you want to arrive at a fair figure:

1. Put down replacement cost of article.
2. Estimate useful life of article.
3. Deduct percentage of use already obtained (based on its useful life).
4. The result should represent generally its current value.

Keep your inventory in a safe place—preferably where it will not be destroyed should fire strike your home.

Here are two basic considerations you should weigh in purchasing adequate insurance protection for your property. They will serve, at least, to raise questions. The answers can be obtained from your local independent agent or broker, who is a specialist in the field.

1. *Regular and frequent review.* The cost of replacing a typical one-family house has increased even in the last five years. Therefore, unless you have reviewed recently the adequacy of the amount of insurance you carry, you should consult your agent or broker about it. The amount of insurance may not be enough to protect you fully as the owner of the property.

2. *Additions or improvements.* The addition of a room, garage, or other property may have increased its value to the point where your insurance is no longer adequate. You should inform your agent or broker of these additions or improvements, and consult him concerning the need for additional insurance coverage. He should be informed periodically of the replacement or addition of household furnishings or equipment so that a revision of the insurance on your dwelling and contents may be effected, as required.

PHILADELPHIA DENTISTS OPPOSE POSSIBLE HOSPITAL CHANGES

MEMBERS of the Pennsylvania State Dental Society have authorized their officers to oppose the Blue Cross proposal to eliminate hospital admissions by oral surgeons and dentists unless the patient suffers accident injuries. Speakers at a recent meeting said the plan would amount to a hidden rate increase for those Blue Cross subscribers requiring hospitalizations for dental service.—*The Bulletin,* Philadelphia.

The *Quest* and three other contestants anchored at Tahiti.

Dentists, Too, Search for Adventure

BY HARRY CIMRING, DDS

Four west coast dentists have recorded their adventures on film and have given pleasure to many television viewers.

TIED DOWN as he is to fine points of instrumentarium, to tiny degrees of operational latitude, and to minute units of histologic structure, it is little wonder that the dentist often yearns to get away from it all through a bold journey or golden voyage and to search for adventure in this wide world.

He might sail a boat to Tahiti or explore Alaska or prospect for uranium in Utah or visit Denmark or Spain or go on safari in wildest Africa. In fact, four dentists did just that, recorded their adventures on film, and had their exploits revealed to the American public via the medium of television.

Jack Douglas, producer of I SEARCH FOR ADVENTURE, GOLDEN

Doctor Murphy, in dark glasses, and some of the crew members of the *Quest*.—*Photographs by Barbara McCartney Murphy.*

VOYAGE, and BOLD JOURNEY, started some two years ago on Los Angeles television station KCOP and now has a world-wide market for his amateur and semi-amateur travelogues, including seventy-five United States outlets, wide distribution in Canada, and Spanish and French language versions for Europe and Latin Ameria, all with excellent viewer ratings.

Douglas contends that people like to see romantic and faraway places and they admire ordinary folk (like the four dentists) who break the routine to do exciting things. The film-makers appear on the program to narrate the travelogue and are also interviewed by Douglas, who serves as master of ceremonies. Aside from the usual cinematographic requirements, the films are 16 millimeters, shot at 24 frames per second, instead of the usual 16, and are taken when possible on a tripod to avoid excessive vibration.

Doctor Howard F. Murphy of Beverly Hills, a graduate of the University of Southern California, 1927, is a devotee of both sailboating and movie-making. He is the owner of the yawl *Quest* and has participated in the biennial Los Angeles-to-Hawaii yacht race as well as the second Los Angeles-to-Tahiti race sponsored by the Trans-Pacific Yacht Club. In between times there are trips to Mexico as well as to northern coastal ports.

It was the Tahiti race in June 1956, which Doctor Murphy photographed, that earned a showing

on television. The race, some 4000 sailing miles, was first held in 1925 and in that one another California dentist also participated. The *Quest,* placing second in a field of five, was manned by a crew of 10 using 21 days and 10 hours to complete the voyage. It served as the monitoring boat with special radio equipment to communicate with the other contestants as to their daily progress and to contact radio station KNX in Los Angeles (CBS), which in turn furnished reports to the news services.

Least enjoyable part of the trip were the day and a half of doldroms encountered 5 to 9 degrees above the equator when the wind was absent but the ocean swells were treacherous, shaking the boat wildly. Below the equator the *Quest* ran into a series of squalls with the usual difficulties and discomforts attendant thereto. The boat arrived at nightfall at its destination without a single accident for the trip or breakdown of electrical gear. At this point, ironically, a crash occurred.

The committee boat, out to welcome the arriving contestant, seeing the sails down, did not realize that the *Quest* was proceeding slowly by motor and misjudged its position. It being after sundown the French custom officials, in typical fashion, refused to inspect the boat until morning. Doctor Murphy, sea-weary after 21 days, his boat damaged, knowing his wife was on board the committee boat during the collision and on the island thereafter, spent an unhappy night aboard ship. His wife had flown down to welcome the boat to its goal. Barbara McCartney Murphy, who comes from a sailing family herself, is a prize-winning photographer and took the still photographs illustrating this article.

In addition to motion pictures and stills of the Tahiti area, Doctor Murphy was able to bring back a number of native artifacts (clothes, spears, and decorations) which were presented to the Los Angeles County Museum. Doctor Murphy has practiced in Carmel and Hollywood (both in California) and twice has had to discontinue his dental practice because of illness, turning first to toy manufacture in England and later to property management. He and Mrs. Murphy have a son, Michael.

Doctor Bernard F. Ederer of La Jolla, California, a graduate of Marquette University, 1923, has appeared twice on the Jack Douglas shows, once with a film describing uranium prospecting in Colorado and Utah. He is also the author of a book based on his Alaska explorations, THROUGH ALASKA'S BACK DOOR[1], and BIRCH

[1] "Side lights on THROUGH ALASKA'S BACK DOOR," an article by Doctor Bernard F. Ederer prepared especially for ORAL HYGIENE was published in September 1954. The July 1957 Picture of the Month showed Doctor Ederer and his family examining a copy of his new book BIRCH COULIE. Also, a two-part article, "Side Lights of Uranium Prospecting," by Doctor Ederer, appears in the April and May 1958 issues of ORAL HYGIENE.

COULIE, based on an historic battle.

Doctor Wilford H. Burwell of Los Angeles, USC, 1929, has appeared twice: once with a film depicting Denmark's North Zieland castles, South Zieland white cliffs and metropolitan Copenhagen; later with a motion picture made of Spain's romantic Andalusia, Flamenco dancers, and cave-dwelling gypsies.

Doctor William B. Treutle, North Pacific graduate, 1941, practiced in Tacoma, Washington, until 1951 when he was given six months to live. He sailed for Uganda, Africa, where he explored and recorded on film the "lost tribe" of Karamojans as a full-length documentary, a portion of which was viewed on one of the Jack Douglas shows.

Quoting the poetess, Elinor Hoyt Wylie, "Farewell, the long pursuit, and all the adventures of his discontent."

240 *South La Cienega Boulevard*
East Beverly Hills, California

SIDE LIGHTS ON URANIUM PROSPECTING

(*Continued from page* 53)

herself gracefully to the boots. Her fortitude through the trying times brought praise for her sex from the many native Utah people we met. Thinking of these friends brings a warm feeling of appreciation to my heart. Wherever we encountered the Mormon people, and whenever we visited with them, we found their hospitality and warm friendship beyond comparison.

We proceeded as far as feasible in this area, and upon completion of our claim markers we decided to try a new country for uranium. Jolting over the rough trail it was almost impossible to stay in the seat. Our jeep was loaded so heavily that I was forced to pack the supply of dynamite under the seat of the vehicle. Every jolt caused my wife's eyes to flash open as if expecting the explosion to follow the bump.

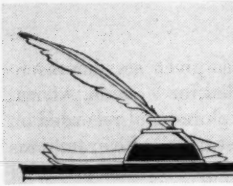
We now headed toward a new territory to prospect, the Nine Mile Canyon country.

But that is another side light story of prospecting for uranium that I will tell you in a later issue.

7532 *La Jolla Boulevard*
La Jolla, California

"SALIVA IN COURT"

A BIRMINGHAM, England, auto dealer was alleged to have sent letters demanding money to two former business associates. The saliva that remained on the envelopes was tested and found to be Group A, the same as the blood group of the accused man. (Blood group antigens are found in the saliva of about 75 per cent of the population.)—*Medical Science, Philadelphia, J. B. Lippincott Company.*



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

The Shameful Fees Under Dental Insurance

AT PRESENT there are three separate group dental care insurance programs licensed to operate in the New York metropolitan area. These plans were organized with the commendable objective of supplying dental care to families with a gross annual income of no more than $5000 a year.

In a study made by a committee of the Dental Society of the State of New York these points were listed as matters of concern to the dental profession:

"(a) The accepted principles of insurance apparently do not apply; (pooling of occasional liability, unpredictable occurrence).

(b) The possible imposition of administrative controls on professional performance.

(c) Interference with a desirable patient-dentist relationship.

(d) Possible administrative channelling of patients—taking patients from one dentist to send to another.

(e) "Bargaining" experience of the group wishing to purchase care on a group basis and the absence of a competent and qualified agency to deal with this problem on behalf of the dental profession. The existence of nonprofit corporations (private) does not compensate or protect the interest of the entire profession.

(f) There is danger in a "bargaining situation" and in the rigid mathematical context of "insurance" administration, that, in an effort to reduce the economic cost of dental care, more and more pressure will be developed to substitute sublevel services for professional dental services. This is a real danger to be guarded against."[1]

Dentists, who are themselves caught in the trap of inflation, despite how altruistic they may be, cannot afford to perform creditable services

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[1]Dental Health Care Programs for Groups, N. Y. State D. J. **23**:438 (November) 1957.
[2]Editorial, Is Dental Care Insurable? ORAL HYGIENE **47**:64 (July) 1957.
[3]Dental Care Insurance Lagging, The Journal of Commerce and Commercial, New York. **254**:1 (October 14) 1957.

for the fees offered to them under the three group dental health plans.

Plan One:

Full mouth x-ray	$3.00
Prophylaxis	2.00
Fillings—one surface	2.50
Fillings—more than one surface	3.00
Extractions	2.00

Plan Two:

An hourly fee of $7.50

Plan Three: The Dental Society of the State of New York mentions an hourly fee that "is slightly more than the standard wage for a carpenter, about equal to a master plumber, and slightly below a tin-smith or tile-setter."

We have commented before on the application of the insurance principle to dental care and have expressed the opinion that groups of people cannot buy insurance of *any kind* when more than 90 per cent of the policyholders are prospective candidates for immediate benefits.[2] The nature of dental disease is such that virtually everyone in the population is in need of dental care. It does not seem, therefore, to be an insurable risk.

On another front, the director of information and research for the Health Insurance Association of America, has expressed the view that dental care should be covered under a major *medical* insurance contract.

"The insurers are concerned over these obvious problems related to dental care:

1. Certain portions of dental work are elective and at times a matter of cosmetic rather than medical necessity. Orthodontia is an example of this.

2. Dental care is not, or need not be, either sudden or sizable in its occurrence; and is more subject to family budgeting in most cases than to be an insurance mechanism.

3. Where costly dental care is needed, it is usually the result of needs accumulated over a number of years prior to the inception of insurance protection and, hence, is a pre-existing condition, generally recognized as being uninsurable."[3]

No one should deprecate the noble motive of group dental care insurance. There are, however, the questions concerning the application of the insurance principle to this kind of coverage and the very real one—a fair cost to the policyholder and a fair fee to the dentist.

Edward J. Ryan

Dentists in the NEWS

Muncie (Indiana) Press: The Distinguished Service Award for 1957 of the Muncie Junior Chamber of Commerce has been presented to Doctor Raymond E. Rothhaar. He serves on the local board of the Indiana Society for the crippled, is a director of the local chapter of the American Cancer Society, and was a leader in founding the Sertoma Icerman Dental Clinic, which offers free dental service for indigent children.

In South Milwaukee, Doctor Harry R. Patin has been awarded the Junior Chamber of Commerce Distinguished Service Award for 1957, according to the *Milwaukee, Wisconsin, Journal*. Doctor Patin was cited principally for his work with South Milwaukee youth as a drillmaster for drill teams and color guards.

Los Angeles (California) Herald Express: Seventy-five dentists and physicians in Los Angeles County are members of the Doctor's Symphony. They rehearse once a week for a three-hour period from September to June every year for their annual concert in January at the Philharmonic Auditorium. The symphony, co-sponsored by the Los Angeles County Medical Association and the Los Angeles Physicians Aid Association, is now in its fourth year.

Bay City (Michigan) Times: Upon completion of his first term as Mayor of Grand Haven, Doctor William Creason, 35-year-old dentist, has announced plans to seek reelection this year.

Iowa City (Iowa) Iowa University Alumni Review: The newly appointed director of dental activities at Walter Reed Army Medical Center is Brigadier General Clarence P. Canby. This marks the dental surgeon's fourth assignment at Walter Reed since he entered the Service in 1927.

Williamsport (Pennsylvania) Grit: For almost twenty years Doctor Walter Jacobs, New York,[1] has been collecting "fists" of famous boxers, and now has more than ninety molds of the fists of fighters. After arranging an appointment, Doctor Jacobs has the fighters dip their fists in modeling compound. Later a bronze impression is made. Molds of the fists are displayed at the Museum of Natural History and the Museum of the City of New York.

At 22, Floyd Patterson, heavyweight champion is the youngest fighter to have his fists preserved for posterity. Jack McAuliffe, retired in 1887, was the oldest. His fist mold was made when he was past 80. Among the other boxing greats Doctor Jacobs has met through his hobby are Benny Leonard, Jack Johnson, Lou Ambers, and Mickey Walker, one of his boyhood heroes.

Columbus (Ohio) Citizen: Doctor Paul Essman has been appointed as Democrat member of the Wellston City Civil Service Commission. Doctor Essman's term for six years started January 1, 1958.

Haddonfield (New Jersey) Gazette: As IT WAS, an autobiography by Doc-

(*Continued on page* 64)

[1]Jacobs, W. H.: Dentistry Gave Boxing the Mouthguard. ORAL HYGIENE **28**:1148 (September) 1938.

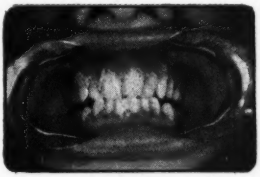
93.3%

effective in periodontal infections

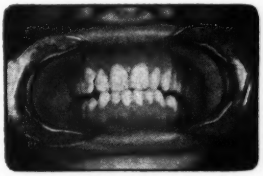
AMOSAN produced improvement in the treatment of gingival inflammation.

AMOSAN (Sodium Peroxyborate Monohydrated buffered with Sodium Bitartrate Anhydrous) used as a mouth rinse, is 93.3% effective in the treatment of inflamed bleeding gums. A rigidly controlled double-blind study at a leading medical center* produced those convincing results.

a typical case history:



First Visit



2 Days Later

Sex: Male
Age: 18

Diagnosis: Acute Vincent's Infection

Treatment: Regular Amosan rinse (No other treatment)

Results: After 2 days, all acute symptoms, pain, swelling, tenderness and infection, were gone.

AMOSAN is a concentrated oxygenating agent that kills anaerobic oral bacteria without the hazards and expense of antibiotics. It also has detergent and hemostatic actions, yet is gentle and non-irritating with an almost neutral pH (approx. 8).

At the first sign of bleeding gums, gingival recession or tooth mobility, use, recommend and prescribe AMOSAN.

Only AMOSAN is available in scientifically designed, individual single-dose packettes. 20 protective packettes per box.

Samples and professional literature available upon request.

*The New York Hospital—Cornell Medical Center. Presented as a Scientific Exhibit at the American Dental Association Annual Session, October, 1957.

AMOSAN

THE KNOX COMPANY Los Angeles, Calif. • Fort Erie, Ont., Canada

tor Milton J. Waas, of Haddonfield, was recently published, not long after the author was honored by South Jersey dentists for his fifty years of service to dentistry. The book is more than a mere account of Doctor Waas' travels and experiences—it includes philosophy, advice on nutrition and gardening, and thumbnail sketches of famous personalities with whom Doctor Waas has associated.

Raleigh (North Carolina) News and Observer: Doctor M. R. Stein, New York, has presented members of his family with paintings he made of their homes. Since he was a youth, Doctor Stein has carved and painted as a hobby. A feature of his New York apartment are African landscapes and scenes of African life, which he painted while on a safari in Africa some years ago.

Milwaukee (Wisconsin) Journal: The Cosmopolitan Club of Milwaukee recently displayed Doctor C. C. Klumb's collection of Bibles. Doctor Klumb, who practices dentistry at 238 West Wisconsin Avenue, has collected about seventy Bibles printed in many languages.

Dayton (Ohio) News: The United States Lawn Tennis Association has presented Doctor Howard Dredge, Springfield, Ohio, with the Hardey award, which was created to honor persons for outstanding work in junior tennis programs. This is the first time the award has gone to someone for work on a local, rather than national level.

Chelsea (Massachusetts) Record: Members of the Chelsea School Board have elected Doctor Jack Rosenfield as Chairman. He was re-elected as a member of the school committee in November 1957, receiving the highest vote in the field of eight candidates.

Springfield (Oregon) News: A coin collection consisting of 400 pieces and valued in excess of $4000 will be displayed in special cabinets in the hallways of Springfield's new Public Library. The collection is the gift of Doctor

(*Continued on page 66*)

W. N. Dow, and represents nearly thirty years of active pursuit of a hobby.

"The story of the many coins in this collection would cover much of the history of the world," said Doctor Dow. "It is my hope that by making a permanent public display of the collection it will stimulate young people of the community to more study of coins and of the history they represent."

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

Carl S. Webb, Jr., 30 North Railroad Avenue, Pedricktown, New Jersey.

Herbert W. Kuhm, DDS, 4729 West North Avenue, Milwaukee, Wisconsin.

Mrs. George T. Ney, 289 Rhoads Avenue, Haddonfield, New Jersey.

Richard Haken, 251 North Jackson, Bay City, Michigan.

B. Vellat, 508 West 62nd Street, Seattle 7, Washington.

Mrs. Henry S. Everett, Roper, North Carolina.

T-Jay Mahoney, 142 Homestead Avenue, Indian Orchard, Massachusetts.

Robert C. Ryan, DDS, 1526 West Jackson Street, Muncie, Indiana.

Mrs. A. Sanderson, PO Box 542, Victorville, California.

Ron Valline, 35 Park Avenue, New York 16.

Robert Weatherford, Lock Box 69-96206, London, Ohio.

Mrs. Raymond J. Hartman, RR 2, Brookville, Ohio.

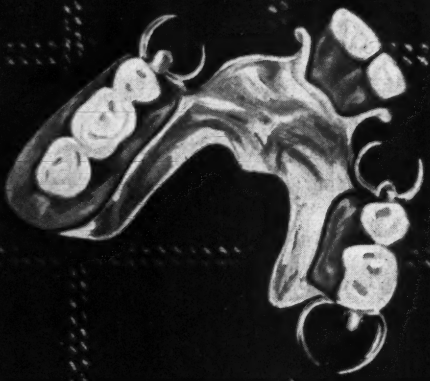
David H. Atchley, South Milwaukee Junior Chamber of Commerce, South Milwaukee, Wisconsin.

Keith Rosenfield, 79 Washington Avenue, Chelsea, Massachusetts.

Mrs. Ralph Geer, 1704 Carter Lane, Springfield, Oregon.

Colonel William Perry, Ret., 18th and Walnut Streets, Philadelphia 3, Pennsylvania.

he best still costs less!



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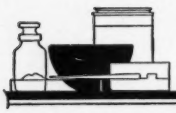


TECHNIQUE of the Month

Originated by W. EARLE CRAIG, DDS

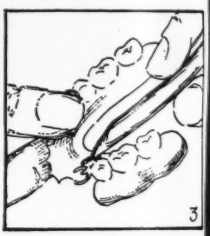
Denture Clasp May Be Re-set Quickly While Patient Receives Dental Treatment

By ROBERT H. BUECKER, DDS

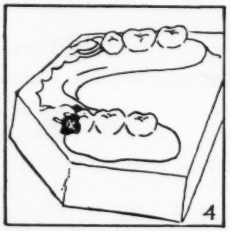
Drawings by Dorothy Sterling

Cut clasp from denture. Roughen the cut edges. Cut small dovetails.

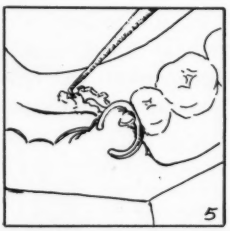
Use warm bite wax to attach clasp in approximate position. Seat denture in mouth. Correct position of clasp. Cool with water. Remove from mouth.



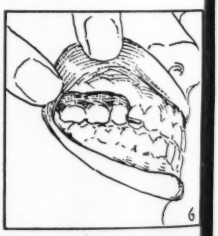
Add sticky wax over the bite wax and re-check position of clasp in the mouth. Cool and remove from mouth.



Oil denture and pour in plaster. (Salt plaster for quick set.) Be sure that clasp ends are secured in the plaster. Let harden. (About 10 minutes.)



Warm the wax and remove it with an explorer. Wipe with wax solvent. Replace wax with quick-repair mix, working mix around clasp tang and into dovetail cuts. Let harden. (20 minutes.)



Use plastic finishing stone to smooth the patch flush with denture. Polish on the lathe. Seat in mouth.

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SELF-CURING DENTURE ACRYLIC

PREMIUM DENTURE ACRYLIC

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on Lang's Acrylics or specific information as to application and procedures direct your inquiry to the attention of Mr. E. Lang, Research.

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ASK Oral Hygiene

Please send all correspondence for this department to: The Editor, *Ask Oral Hygiene*, 708 Church Street, Evanston, Illinois. Enclose a stamped, addressed envelope for a personal reply. If x-ray films are sent, they should be protected with cardboard. We cannot be responsible for casts or study models that are mailed to this department.

Canker Sores

Q.—I should like some information regarding canker sores of an aphthous nature. I have been touching the affected areas with an 8 per cent zinc chloride solution, which gives some relief; but it takes about a week to cure the condition, and it recurs in about a week. The sores appear at the base and tip of the tongue, and on the lips. Would it be advisable to touch these places with a saturated solution of trichloracetic acid? —S.O.S., Colorado

A.—The condition described in your letter is, as you suggest, one of canker sores, or as given in a late publication,[1] "herpetic gingivostomatitis." This authority gives as the etiology "herpes simplex virus, but without symptoms due to low-grade immunity. Injury due to coarse foods, or dental treatment, or systemic diseases, may play an important role in lowering the resistance of the tissues to the attack of the already present virus."

Allergy to foods is not given in the etiology in the foregoing authority, but I have, through clinical experience, found food allergy a common etiologic factor. One patient who had constantly recurring multiple canker sores, had allergy tests made which revealed wheat as her principle food allergen. She reduced her wheat intake to a minimum and had no more canker sores.

I have found that touching a canker sore with a saturated solution of trichloracetic acid will relieve the pain and soreness and cure the sore.

In cases in which the condition is more of an aphthous nature, antihistamines are helpful.—V. C. SMEDLEY

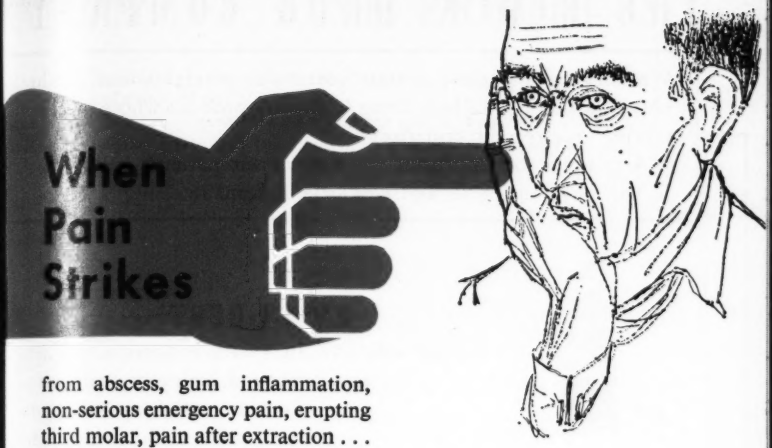
[1]Orban, B. J. and Wentz, F. M., Atlas of Clinical Pathology of the Oral Mucous Membrane, The C. V. Mosby Company, 1955.

Soreness at Corners of Mouth

Q.—I should appreciate any information you could give me for the treatment of a patient who has had fissures in the corners of his mouth for several months. They have not responded to any treatment.—W. T. S., New York

A.—In reply to your recent question, soreness frequently occurs at the corners of the mouth from the seeping of saliva into the deep wrinkles in shortened bite or edentulous cases. I have corrected such cases by opening the bite with new dentures with enlarged buccal contours to lessen the depth

(*Continued on page 74*)



from abscess, gum inflammation, non-serious emergency pain, erupting third molar, pain after extraction . . .

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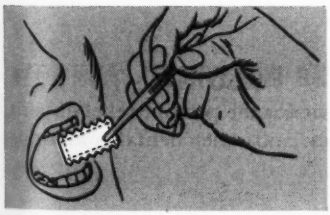

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A product so *tested* that you know your patients will accept it, will enjoy using it, and will benefit from it.

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proved effective in caries reduction . . .
recommended by more dentists
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GREEN MINT

detergent mouthwash with fresh minty
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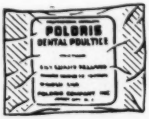

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"Quality Products for Dental Health"

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the professional toothbrush with Py-co-*TIP* – recommended by more dentists than any other toothbrush . . . also salt and soda tooth powder

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speeds the mastery of the new denture – recommended by more dentists than any other denture adhesive

WERNET'S DENTU-CREME

non-abrasive cleansing cream specifically formulated for dentures

WERNET DENTURE BRUSH

reaches all parts of the denture and gives long lasting wear

A Family of Fine Products for Your Family of Patients

of the wrinkles at the corners of the mouth. You can try this out by building wax on for buccal contour and raising the bite with a temporary rebasing with modeling compound, and letting the patient wear his present dentures this way for a few days.—V. C. SMEDLEY

Hepatitis

Q.—A local physician tells me that in about ninety days a hepatitis can develop from the routine use of a local anesthetic by a dentist. Is this true?—E. L. W., Indiana

A.—In response to your question I suggest that you read the following editorial published in DENTAL DIGEST in July 1957, indicating the possibility of dental instruments being carriers of viral hepatitis:

This is the day of emphasis on viral infections. Many of the cases of respiratory tract infections carry the virus label. There is increasing evidence that some cases of malignant disease are of viral origin. Infectious hepatitis and serum hepatitis are commonplace conditions of involvement of the liver by viruses.

Dentists must be particularly concerned with their techniques of sterilization of needles and syringes because of the danger that these instruments may be the carriers of viral hepatitis from one patient to another.

An editorial "Serum Hepatitis and Dental Injections" from the *British Medical Journal* gives this report and warning to dentists:[1]

"During a two-year period from June 1953, to May 1955, fifty-seven patients were discharged from the General Hospital in Rochester, New York, with the diagnosis of viral hepatitis. Seven of these were known to have received blood or plasma transfusions. The remaining fifty patients would normally have been diagnosed as having suffered from infectious hepatitis, but fifteen of them gave a history of a dental injection within the preceding six months. In these fifteen patients there was no history of contact with a known case of infectious hepatitis, whereas there was such a history in six of the thirty-five patients who had no dental history. The incubation period in the fifteen cases varied from 47 to 142 days, with a mean of 96 days. The onset of illness was fairly gradual in most patients. The first symptoms were usually malaise, fatigue, and loss of appetite, with nausea and abdominal ache. The interval from the first symptoms to the onset of jaundice was usually one to two weeks. Three patients died with diffuse or focal necrosis of the liver cells. Foley and Gutheim suggest that the association of these patients with a history of past dental treatment was not just due to chance. Whereas in the whole group of fifty patients with hepatitis included in this investigation fifteen (or 30 per cent) had a history of dental injections, in two other control groups of pa-

(*Continued on page* 76)

[1]British Med. J. No. **5019**:636 (March 16) 1957.

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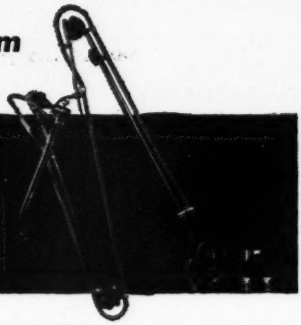

Compact engine arm assembly.

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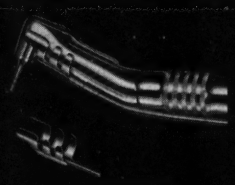

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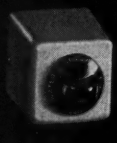

Tri-Jet coolant selector switch.

tients the frequency of dental injections was five to seven times less—4.4 per cent in one group of sixty-eight patients and 6 per cent in another group of fifty patients.

"These and other data which the authors give strongly suggest that dental injections must now be added to the list of injections which can be responsible for the transmission of virus hepatitis. Certainly the authors have established a case for careful investigation of this potential hazard. The risks of introducing infections by means of contaminated syringes or needles are not as widely appreciated as they should be. This is partly because many doctors [sic] and dentists are not aware of having had any trouble of this kind in their own practices, and if challenged on their technique for sterilizing syringes would point to the large numbers of injections they have given without any ill effects. But there is today an increased awareness that methods of sterilization both of syringes and of solutions frequently used in hospital and in general practice are far from safe. Foley and Gutheim recommend that chemical sterilization should be abandoned, and advise careful cleaning of syringes and needles and heat sterilization both of these and of procaine solutions. The days when every dentist will have his own small autoclave in his surgery may be some way off, but, if the risk of serum hepatitis suggested by Foley and Gutheim is confirmed by further investigation, then there will cer-

(*Continued on page* 78)


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NEW BENEFITS for
QUICKER CONTROL OF DENTAL INFECTIONS
PLUS OUTSTANDING FEATURES
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tainly be a case for overhauling the methods at present in use. The high mortality of serum hepatitis makes it a disease with which no chances must be taken."

In this day of high speed techniques and other refinements in dental procedures we need to take a close and critical look at some of our other methods: the sterilization of dental instruments.

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ CLXIII

(See page 39 for questions)

1. Because of danger of perforating the palate. (Eskin, L. C.: Surgical Preparation for Oral Prosthesis, DENTAL DIGEST **62**:507 November 1956)
2. True. (Ney Bridge & Inlay Book, Hartford, Connecticut, J. M. Ney Company, 1954, page 63)
3. (a). (Fisher, A. A.: Allergic Sensitization of the Skin and Oral Mucosa to Acrylic Resin Denture Material, J. Pros. Dent. **6**:593 September 1956)
4. No. (Gwynn-Evans, E.: Mouth Breathing, M. Press **235**:247 March 21, 1956)
5. (b). (Tausig, D. P.: Application of Anesthetics and Analgesic Agents to Dentistry, JADA **51**:398 October 1955)
6. The second molars (Sayre, L. D.: The Aging Mouth, DENTAL DIGEST **62**:502 November 1956)
7. (b). (Lammie, G. A.: Some Factors Affecting the Full Lower Denture, Fort. Rev. Chicago

(*Continued on page* 80)

Here's a unique opportunity to own a profitable business

OPEN A PHILCO-BENDIX SELF-SERVICE LAUNDRY STORE!

Today, many doctors, lawyers, professional and business men of all kinds are going into the self-service laundry business. The reasons are obvious. Many of these new-type laundry stores are delivering excellent returns on a small capital investment.

Here are some of the facts: The coin-operated laundry is one of the fastest growing businesses in the country. Customers simply come into the store, wash and dry their clothes in metered machines and leave. They bring their own washing supplies or buy them from vending machines in the store.

Minimum supervision required: A coin-operated laundry needs no attendant. Only a couple of hours a week is required to empty the coin boxes and supervise efficient operation. There are no credit problems – strictly a cash business. Machine repair and daily maintenance are contracted to local people. You can spend full time with your regular business or practice and let the coin store run itself.

Why are they so successful? Coin-operated laundry stores offer customers up to a 65% saving over attended type wash and dry service. They are convenient for busy people because they remain open 24 hours a day, seven days a week. They give customers a chance to do their own washing – their own way.

Small initial investment: The overall cost of opening one of these stores, equipped with Philco-Bendix Commercial Washers, is surprisingly low. Return is so rapid that many investors amortize the total cost within a year. Local Philco-Bendix Commercial Laundry distributors can provide financial data from other stores in the area.

Act now! Why not investigate this exciting new business opportunity today! Send the coupon below for full information. Complete data on business locations in your area and valuable help in all phases of planning, financing and promoting a coin-operated laundry store are available from local distributors.

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Please send me information on Philco-Bendix Commercial Washers . . . also the name of my local distributor.

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*City*_____ *Zone*____ *State*_____

Philco-Bendix Commercial Laundry Equipment is brought to you by Philco Corporation

PHILCO BENDIX

COMMERCIAL LAUNDRY SALES

D. Soc. **32**:9 July 1, 1956)

8. True. (Bunting, R. W.: Oral Hygiene and Preventive Dentistry, Philadelphia, Lea & Febiger, 1950, page 110)
9. No. (Accepted Dental Remedies, 22nd Ed, American Dental Assoc., 1957, page 102)
10. (c). (Phillips, R. W.: Research on Dental Amalgam and its Application in Practice, JADA **54**:310 March 1957)

DEAR ORAL HYGIENE

A New Angle

A woman of about sixty years called at my office wearing her fourth set of dentures. Her nose and chin were too close together due, perhaps, to the absorption of the underlying bony structures. We made her new dentures and raised and balanced her bite.

A month later she called at the office for a denture adjustment. She stated that her hearing was greatly improved, her right ear being normal, but the hearing in the left ear was still a bit "foggy." She also said that she was glad she had spent her money for a new set of dentures instead of a hearing aid.

Then our big surprise came when she stated that she honestly believed these dentures had also helped her eyesight. In the past 47 years of practice I have never before had a patient make such a statement to me.

I discussed this matter of new dentures with raised and balanced bite with an eye specialist and with an eye, ear, nose and throat specialist, and neither of them had ever had an experience like this.

We have been raising and balancing the bites in many cases with favorable results regarding their hearing, but never before have we heard any comment about the eyes. Since this is a new approach to the value of prosthetic den-

(*Continued on page* 81)

tistry, I wish to submit it to your readers.—E. JEFF HALFORD, DDS, 536 *Olive, Fresno 4, California.*

Dental Caries Treatment

In the article in December ORAL HYGIENE entitled, DENTISTRY CONTRIBUTES TO HUMAN HAPPINESS,[1] reprinted from the *New England Journal of Medicine*, its writer expressed criticism as to the value of dental caries treatment. The principal claim made, that mechanical treatment of caries is never curative, is misleading and thus open to challenge. Dental history shows that before any dental school existed similar arguments were made by some in the medical profession in denying the request, made by dentists, that medical schools provide training in dental therapeutics. All surgery is mechanical in nature but only so, in procedure, to accomplish an objective.

During years of practice I have observed many cases in which teeth received surgical caries treatment, which stood up after years of normal service. I feel sure many others in the profession have had similar experiences.

Clinical observation backed by research study in dental schools has disclosed reliable evidence that a disturbed body chemistry from unbalanced dietary in due time creates an acid condition of oral secretions in many cases (dental acidosis), thereby subjecting tooth structure to the process of caries and recurrence of caries in some of the treated teeth.

Corrective treatment of dental acidosis resulting from an unbalanced diet is part of modern dental practice, and effective especially in children. Also, this type of treatment in uncomplicated cases will prevent dental caries and the recurrence of caries in many cases of restored carious teeth. Cases of dental caries arising solely from local causative factors, such as remains of foodstuffs lodged on or in between teeth, usually may be removed by brushing after meals. Persistent salivary calculus deposits on tooth surfaces call for both

(*Continued on page 82*)

[1]Dentistry Contributes to Human Happiness, ORAL HYGIENE **47**:57 (December) 1957.

local and dietary attention.—Herbert H. Schmitt, DMD, 2015 *North Kilpatrick Street, Portland* 17, *Oregon.*

Men of Science and X-rays

The controversy raging around the question of whether the use of the x-ray machine is always safe, or whether there is serious danger in its application should never have gone down to the level of recrimination and gratuitous insults. I refer to a contribution in your issue of January 1958 under the title DENTAL X-RAYS ARE SAFE![2]

Regardless of the merits at issue, your contributor used bad taste in accusing two great atomic energy scientists of seeking cheap publicity and "of trying to impress the public for gain and temporary reputation." What possible gain could accrue to these great scientists who have compiled the data and presented them as they saw fit? What possible reputation is your contributor alluding to? The men of science in physics, genetics, chemistry, and pathology, who have made a study of radiation and its effects upon living tissue need not offer any excuses to us or to anybody else for their views on this all vital question. Certainly they do not deserve any uncalled for vituperation.

Perhaps we should rather learn to listen to others and heed our steps. I need not remind you that many x-ray men who pioneered and experimented in this field have themselves suffered a great deal from the effects of radiation. —S. P. Ratner, DDS, 31-58 *Steinway Street, Long Island City, New York.*

[2]Meistroff, C. L.: Dental X-rays Are Safe! ORAL HYGIENE **48**:36 (January) 1958.

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1. J. Dent. Research *28*:248, 1949
2. Oral Surg., Oral Med., & Oral Path. *5*:155, 1952

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DRUGS FOR PREMEDICATION OF THE DENTAL PATIENT

THE BARBITURATE group still remains the most widely used drug group for premedication of the apprehensive dental patient, or the patient who reacts to local anesthetics. Meperidine (Demerol®) may be used for patients who do not react well to the barbiturates. The recently introduced tranquilizing drugs are being used experimentally for premedication of the apprehensive patient, and appear to have promise of successful dental use. Their chief advantage is that they give a feeling of assurance to the patient without the drowsiness which accompanies the barbiturates. Their use must be considered experimental and not completely evaluated. Possibly the member of this group currently showing the greatest promise in dentistry is meprobamate (Miltown®- Equanil®).

The skeletal muscle depressants are being tried to reduce muscle spasm in the spastic dental patient. No conclusions can be drawn at the present time, but mephenesin (Tolserol®) has shown some value in this respect, and it is possible that as other members of this group are studied, we may find one with still greater merit.

Methantheline (Banthine®) is now being used extensively in dentistry in place of atropine as an antisialogogue.

New Local Anesthetics: A number of new local anesthetic agents have considerable merit. Lidocaine (Xylocaine®) is different chemically from procaine, and can be used safely by dentists who are sensitive to procaine. In addition, it produces anesthesia of greater duration and greater depth than procaine. Other new local anesthetic agents which will be used widely in dentistry include Unacaine, Primacaine, Oracaine and Ravocaine.

Drugs for Postoperative Pain Control: The antipyretic group (acetylsalicylic acid, acetaphenetidin and A.P.C. compounds) appear still to be the drugs of choice for mild to moderately severe dental pain. For more severe pain codeine is still widely used, but there is an increasing use of meperidine (Demerol) and methadon.

Dental Antibiotic Therapy: The current trend in dental antibiotic therapy includes avoidance of topical penicillin with substitution of bacitracin, neomycin, polymyxin, or combinations of these latter agents; and more emphasis on oral administration of penicillin when it is used systemically, with an increasing use of Phenoxymethyl Penicillin (Penicillin "V"). Erythromycin and Carbomycin appear to be suitable substitutes for penicillin in the sensitized patient, particularly if the patient also reacts unfavorably to the broad spectrum antibiotics.—F. D. OSTRANDER, from *Proceedings of the Institute of Medicine of Chicago*, May 1957.

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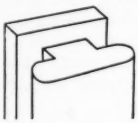

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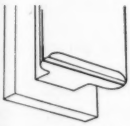

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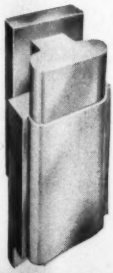

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LAFFODONTIA

"They laughed when I spoke to the waiter in French—they didn't know I told him to give the check to the other guy."

★

The human brain is a wonderful thing. It starts working the moment you are born and never stops until you stand up to speak in public.

★

The minister's wife had just died, and wishing a week's leave from his pulpit he wrote his bishop:

"I regret to inform you my wife has died. Please send a substitute for the week end."

★

The ship's first officer told a deck hand to go below and break up a crap game. In about an hour the sailor returned.

"Did you break up the game?" asked the officer.

"Yes sir."

"Well, what in thunder kept you so long?"

"I had only three bucks to start with, sir."

★

"Really Bill, your argument with your wife was most amusing."

"Wasn't it though? When she threw the axe at me, I thought I'd split."

★

The great psychiatrist was examining the precocious youth. "What would happen if I cut off your left ear?" he suddenly asked.

"I couldn't hear," the boy replied quickly.

"Then what would happen if I cut off your right ear?"

"I couldn't see!" came back the answer.

The great psychiatrist stared, then turned to the mother. "This is a serious case!" He swung back to the boy. "Why do you say you couldn't see if I cut off your right ear?"

"Cuz my hat would slide down over my eyes!" snapped the kid.

★

A fellow carrying a hundred-pound bomb got on the London bus and sat down.

"What's that you've got on your lap?" asked the conductor.

"It's a delayed-action bomb. I'm taking it to the police station," came the answer.

"Lumme," said the conductor, "you don't want to carry a thing like that on your lap. Put it under the seat!"

★

The difference between an old maid and a cutie is that the cutie goes out with the Johnnies while the old maid sits home with the willies.

★

"Little boy, doesn't your conscience tell you when you've done wrong?"

"Yes, but I'm mighty glad it doesn't tell dad."

★

Heavy-footed Dancer: "May I have the last dance with you?"

Partner (coldly): "You've just had it."

★

Alex: "I don't know which girl to take to the pictures."

Bill: "Why not toss up?"

Alex: "I have, but it didn't come out right."